A

SIOW CHING YEE (MENYAMAN MELALUI ISTERI DAN WAKIL LITIGASINYA, CHAU WAI KIN) v. COLUMBIA ASIA SDN BHD

FEDERAL COURT, PUTRAJAYA
MOHAMAD ZABIDIN MOHD DIAH CJ (MALAYA)
B ABDUL RAHMAN SEBLI CJ (SABAH & SARAWAK)
ZABARIAH MOHD YUSOF FCJ
HASNAH MOHAMMED HASHIM FCJ
MARY LIM FCJ
[CIVIL APPEAL NO: 02(f)-12-02-2023(B)]
C 23 FEBRUARY 2024

Abstract – *The principle of non-delegable duty is founded on established concepts entrenched in the general principles of the law of negligence. An assumption of responsibility gives rise to a positive duty* D *to protect the claimant from harm, and forms the rationale for imposing a more onerous duty of care on the defendant. The obligation/liability is imposed because of the existence of an antecedent relationship between the parties apart from that between the claimant and the tortfeasor. The duty that is imposed is a positive duty to protect the claimant, who is* E *of a particular class, against particular risks and that duty arises because of the relationship which is personal to the defendant. Under these conditions, such a defendant is treated in law as having assumed responsibility for the exercise of due care by anyone to whom he may delegate its performance.*

F

TORT: *Negligence – Medical negligence – Duty of care – Non-delegable duty of care – Claimant suffered severe brain damages as result of treatment rendered by third party medical specialists who practised at private hospital – Whether hospital owed non-delegable duty of care to claimant – Whether five features in Woodland* G *v. Swimming Teachers Association & Others applied – Whether claimant was patient who was especially vulnerable or dependent on hospital against risk of injury – Whether there was antecedent relationship between claimant and hospital independent of negligent act or omission itself – Whether claimant had no control over how hospital chose to perform obligation, ie, whether personally or through* H *employees or third parties – Whether hospital had delegated to third party some function which was integral part of positive duty which it had assumed towards claimant – Whether third party exercised delegated function – Whether third party negligent in performance of function assumed and delegated by hospital – Private Healthcare Facilities and Services Act 1998 – Private Healthcare Facilities and* I *Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006*

TORT: *Damages – Quantum – Multiplicand – Loss of earnings – Claimant suffered severe brain damages as result of treatment rendered by third party medical specialists who practised at private hospital – Compensation ought to be accorded – Multiplicand only recognised claimant's basic salary – Multiplicand disregarded claimant's earnings derived from allowances, fees and monthly salaries received as director of companies for which tax had been paid – Different multiplicand used depending on pre-trial or special damages – Whether computation of multiplicand correct – Civil Law Act 1956, s. 28A*

STATUTORY INTERPRETATION: *Statutes – Civil Law Act 1956, s. 28A – 'earnings by his own labour or other gainful activity' – Whether earnings derived from allowances, fees and monthly salaries received as director of two companies for which tax had been paid fell within meaning of 'earnings by his own labour or other gainful activity' under s. 28A*

The appellant had undergone a tonsillectomy, palatal stiffening and endoscopic sinus surgery at a different hospital before he was brought to the Accident and Emergency Department of the respondent, a private hospital, 12 days later, following bleeding at the site of the operation. There, the appellant was examined by a medical officer who then called a consultant ear, nose and throat surgeon ('first defendant'). The first defendant recommended that the appellant undergo an examination and wound debridement under general anaesthesia and, for this purpose, the appellant was attended to by a consultant anaesthetist ('second defendant'). The appellant vomited copious amounts of blood and experienced profuse bleeding, before the surgery started. He then collapsed and had to be resuscitated. The surgery was carried out where the appellant suffered hypoxic brain damage. The appellant is now permanently mentally and physically disabled. The appellant, through his wife, commenced a suit at the High Court against the first and second defendants and the respondent (the third defendant then) for negligence and for their breach of duties under the Private Healthcare Facilities and Services Act 1998 ('Act'); it was averred that the respondent was vicariously liable for the negligence of the first and second defendants and was directly liable for breach of its non-delegable duty. The High Court (i) dismissed the claim against the first defendant; (ii) allowed the claim against the second defendant; and (iii) dismissed the claim against the respondent on the grounds that: (a) the appellant failed to establish negligence against the respondent; and (b) on the issue of vicarious liability and direct non-delegable duty, the first and second defendants were independent contractors, not employees, servants or agents of the respondent, as evinced by the resident and consultant agreement. Dissatisfied, the appellant and the second defendant appealed to the Court of Appeal; the appellant's appeal was in respect of the second defendant and the respondent and on quantum. The Court of Appeal (i) dismissed the appellant's appeal against the respondent; and (ii) allowed in part the

appellant's appeal against the second defendant in respect of quantum. Hence, the present appeal against the respondent. The central issue for determination was whether the respondent owed a non-delegable duty of care to the appellant.

Held (allowing appeal)
Per Mary Lim FCJ (majority judgment):

(1) In the English case of *Woodland v. Swimming Teachers Association & Others* ('*Woodland*'), a non-delegable duty would arise if the following defining features are present: (i) the claimant is a patient or a child, or for some other reason, is especially vulnerable or dependent on the protection of the defendant against the risk of injury ('first feature'); (ii) there is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, which: (a) places the claimant in the actual custody, charge or care of the defendant; and (b) from which, it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant ('second feature'); (iii) the claimant has no control over how the defendant chooses to perform those obligations, *ie*, whether personally or through employees or third parties ('third feature'); (iv) the defendant has delegated, to a third party, some function which is an integral part of the positive duty which he has assumed towards the claimant, and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it ('fourth feature'); and (v) the third party has been negligent, not in some collateral respect, but in the performance of the very function assumed by the defendant and delegated by the defendant to him ('fifth feature') ('five *Woodland* features'). (para 32)

(2) The five *Woodland* features were met in this case. The first feature was easily fulfilled; the appellant was indeed in a vulnerable position and was totally reliant on the respondent for its care and treatment – more so when the appellant was admitted to its emergency services. The second feature was well met by both the statutory framework which puts into place a relationship which deems an assumption of a non-delegable duty of care and also from the factual circumstances. The appellant was admitted to and in the respondent's emergency facilities and treated by its medical officer, prior to being referred to the first and second defendants. These defendants were also part and parcel of the necessary professionals who must be available if the respondent was to provide emergency services on a routine basis. More importantly, the negligent act complained of took place during the care and treatment rendered within the respondent's premises using its facilities and services; it did

not happen anywhere else. As for the third and fourth features, it was clearly evident that the appellant had no control over how the respondent was to perform its function of rendering emergency care and treatment; whether it would be rendered personally or through employees or some third parties such as the professionals it had engaged and to whom it had delegated the integral function of treatment and care of patients at its emergency services. In fact, having assumed a positive duty of care to the appellant in respect of emergency services, the respondent had delegated to its medical officer, and to the first and second defendants, the performance of its obligations and these persons were indeed performing those delegated functions. As for the fifth feature, it was undeniable that the second defendant was negligent in the performance of the very function of rendering proper emergency care and treatment of the appellant that was assumed by the respondent but delegated to her by the respondent. With all five features satisfied, it was clear that the respondent had assumed a non-delegable duty of care that it owed personally to the appellant. The defence of independent contractor thus was not sustainable in law and ought to have been rejected by the courts below. (paras 80-81 & 84-86)

(3) The Act applies to all healthcare facilities and services which are not provided by the Government through public hospitals or institutions. The provisions of the Act and the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 fortify the understanding that the hospital is and remains responsible for not just the efficacy of premises or facilities but also for the treatment and care of the patients; regardless of how and who the responsibility may have been delegated to. This is the intent of the legislative scheme, to the extent that the policy of the private hospital or healthcare facility or service is required to be placed in a conspicuous place of the premises so that persons coming to the hospital or healthcare facility or service are aware of such policy. Implicit in this structure and legislative scheme is already the balance and incorporation of the elements of fairness, just and reasonableness which need not be reconsidered as an entirely separate exercise or consideration. (para 77)

(4) The appellant was awarded compensation for loss of earnings as per the following: (i) special damages totalling RM265,200, calculated on a multiplicand of RM2,600 per month x multiplier of 90 months; and (ii) pre-trial damages totalling RM88,380, calculated on a multiplicand of RM2,946 per month x multiplier of 30 months. In respect of the multiplicand, the High Court fixed it at RM2,600 per month. This figure was said to disregard the appellant's earnings derived from allowances, fees and monthly salaries received as a director of two companies for which tax had been paid. The multiplicand only recognised his basic

salary. A different multiplicand was used, depending on whether it was pre-trial loss or special damages. The courts below fell into error in disregarding these earnings when computing the multiplicand, and in recognising different multiplicand. These earnings, for which tax had been paid, were clearly within the meaning of 'earnings by his own labour or other gainful activity' under s. 28A of the Civil Law Act 1956 and should thus be recognised. As for the multiplicand, that should be constant. The correct award should be a constant sum of RM8,750 per month with the multipliers as suggested by the appellant. There was no reason to disturb the exercise of discretion of awarding interest at the rate of 4% per annum for the relevant periods. The respondent sought an order that the second defendant indemnify the respondent in the event that it is found liable. This was not right nor available in law as the second defendant was not a party to this appeal and, more importantly, it flew in the face of the earlier findings that the respondent owed a non-delegable duty of care and it remained liable regardless to whom it may have employed or engaged to carry out that duty of care. (paras 87, 89 & 92-95)

Per Zabariah Mohd Yusof FCJ (dissenting):

(1) The present appeal fell neatly within the established category of independent contractors. There was no ambiguity in the relationship between the second defendant and the respondent, as evident from the resident and consultant agreement. There was no issue of the appellant being deprived of remedy or compensation for the negligent act of the second defendant. It was a straightforward case of a true independent contractor, where there was no necessity to go through the circuitous route to invoke the principle of a non-delegable duty so as to make the respondent liable, when the direct course of remedy, according to the law of torts, was readily available to the victim. (paras 165 & 237)

(2) The imposition of non-delegable duty of care are highly fact-sensitive. Accusations outside of well-established principles, to say that such non-delegable duty of care exists, need to be properly scrutinised and applied with extreme caution, given that non-delegable duty is inconsistent with fault-based principles and is exceptional. The underlying framework in which the identifying features were crafted in *Woodland* had substantial restrictions and controls and would only be in exceptional situation before the duty could be found to be a non-delegable one. The criteria for an antecedent relationship, positive duty and integral function has high threshold to be met. *Woodland* had not widened the scope of non-delegable duty of care. Often, there is a tendency to look for a defendant who has deeper pockets, to satisfy compensation claims under the guise of non-delegable duty of care,

when there is a clear case of an independent contractor or employer-employee relationship, which sets a worrying trend. In the present appeal, the respondent was providing critical health service where the appellant was treated earlier in another hospital and was brought to the respondent due to a critical and emergency life-and-death situation. *Woodland* had cautioned against imposing unreasonable financial burdens on those providing critical public services and that a non-delegable duty should be imputed only so far as it would be fair, just and reasonable to do so. Where the criteria of the framework is satisfied, the imposition of a non-delegable duty would not cast an unreasonable burden. However, that was not the case here. (paras 233 & 234)

(3) Caution should be exercised when courts expand the area of liability of non-tortfeasors (where the courts are expanding areas of vicarious liability). This is the realm of policy, which is an unfamiliar territory for the courts and if such duty ought to be expanded and imposed on private hospitals or medical institutions like the respondent, it would be wise for it to be provided by legislation since it affects medical institutions and the medical profession who are independent contractors, which technically are not being controlled in the performance of their medical duty by hospitals like the respondent. (para 235)

(4) The doctrine of non-delegable duty was not applicable to the fact situation of the present appeal. The appeal was dismissed with costs. Both the High Court and the Court of Appeal did not err in dismissing the appellant's claim against the respondent. There was no statutory duty imposed on the respondent that would render the latter liable for the negligence of a registered medical practitioner who was an independent contractor and not an employee of the hospital. (para 237)

Bahasa Melayu *Headnotes*

Perayu telah menjalani pembedahan tonsilektomi, pengerasan lelangit dan sinus endoskopik di hospital lain sebelum dia dibawa ke Jabatan Kemalangan dan Kecemasan responden, sebuah hospital swasta, 12 hari kemudian, ekoran pendarahan pada bahagian yang dibedah. Di situ, perayu diperiksa oleh seorang pegawai perubatan, yang seterusnya memanggil pakar perunding pembedahan telinga, hidung dan tekak ('defendan pertama'). Defendan pertama mencadangkan agar perayu menjalani pemeriksaan debridmen luka dengan bius am dan, bertujuankan ini, perayu dirawat oleh pakar perunding bius ('defendan kedua'). Sebelum pembedahan bermula, perayu muntah darah dan mengalami pendarahan yang teramat banyak. Dia kemudian pengsan dan terpaksa disedarkan semula. Pembedahan lalu dijalankan dan perayu mengalami hipoksia kecederaan otak. Perayu kini kekal hilang upaya mental dan fizikal. Perayu, melalui isterinya, memulakan satu guaman di Mahkamah Tinggi, terhadap defendan pertama dan kedua dan responden (ketika itu defendan ketiga), atas kecuaian dan pelanggaran

kewajipan mereka bawah Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 ('Akta'); ditegaskan bahawa responden bertanggungan secara vikarius atas kecuaian defendan pertama dan kedua dan bertanggungan secara langsung atas pelanggaran kewajipan berjaga-jaga yang tidak boleh diwakilkan. Mahkamah Tinggi (i) menolak tuntutan terhadap defendan pertama; (ii) membenarkan tuntutan terhadap defendan kedua; dan (iii) menolak tuntutan terhadap responden atas alasan: (a) perayu gagal membuktikan kecuaian responden; dan (b) bersangkutan isu tanggungan vikarius dan kewajipan langsung berjaga-jaga yang tidak boleh diwakilkan, diputuskan bahawa defendan pertama dan kedua adalah kontraktor bebas dan bukan pekerja, kakitangan atau ejen responden, dan ini terbukti melalui perjanjian residen dan pakar perunding. Tidak berpuas hati, perayu dan defendan kedua merayu di Mahkamah Rayuan; rayuan perayu melibatkan defendan kedua dan responden serta kuantum. Mahkamah Rayuan (i) menolak rayuan perayu terhadap responden; dan (ii) membenarkan sebahagian rayuan perayu terhadap defendan kedua berkaitan kuantum. Maka timbul rayuan ini terhadap responden. Isu utama untuk diputuskan adalah sama ada responden mempunyai kewajipan berjaga-jaga, yang tidak boleh diwakilkan, terhadap perayu.

Diputuskan (membenarkan rayuan)
Oleh Mary Lim HMP (keputusan majoriti):

(1) Dalam kes Inggeris *Woodland v. Swimming Teachers Association & Others* ('*Woodland*'), kewajipan berjaga-jaga yang tidak boleh diwakilkan timbul jika wujud ciri-ciri khusus berikut: (i) pihak menuntut adalah seorang pesakit atau seorang kanak-kanak, atau atas sebab lain, lebih mudah terdedah pada bahaya atau bergantung pada perlindungan defendan terhadap risiko kecederaan ('ciri pertama'); (ii) wujud hubungan anteseden antara pihak menuntut dengan defendan, yang bebas daripada tindakan atau ketinggalan cuai itu sendiri, yang (a) meletakkan pihak menuntut dalam jagaan atau tanggungjawab defendan; dan (b) berdasarkan itu, adalah mungkin untuk mengatakan defendan menggalas kewajipan positif untuk melindungi pihak menuntut daripada bahaya dan bukan sahaja kewajipan mengelak daripada tindakan boleh-jangka yang akan menjejaskan pihak menuntut ('ciri kedua'); (iii) pihak menuntut tidak mempunyai kawalan atas bagaimana defendan memilih untuk melaksanakan kewajipan-kewajipan ini, iaitu, sama ada secara kediri atau melalui pekerja-pekerjanya mahupun pihak ketiga ('ciri ketiga'); (iv) defendan mewakilkan, pada pihak ketiga, fungsi yang merangkumi aspek penting kewajipan positif yang digalasnya terhadap pihak menuntut dan pihak ketiga itu menjalankan, bagi tujuan fungsi yang diwakilkan padanya, jagaan defendan terhadap pihak menuntut dan elemen kawalan yang seiring dengannya ('ciri keempat'); dan (v) pihak ketiga cuai, bukan dalam aspek kolateral, tetapi dalam pelaksanaan fungsi yang digalas oleh defendan yang diwakilkan oleh defendan padanya ('ciri kelima') ('lima ciri *Woodland*').

(2) Lima ciri *Woodland* telah dipenuhi dalam kes ini. Ciri pertama dipenuhi dengan mudah; perayu sememangnya dalam kedudukan yang terdedah pada bahaya dan bergantung penuh pada responden untuk jagaan dan rawatan – apatah lagi kerana perayu diwadkan berasaskan perkhidmatan kecemasannya. Ciri kedua dipenuhi oleh rangka kerja undang-undang yang menetapkan hubungan yang menentukan penggalasan kewajipan berjaga-jaga yang tidak boleh diwakilkan dan juga berdasarkan hal keadaan fakta. Perayu diwadkan dan diletakkan bawah kemudahan kecemasan responden serta dirawat oleh pegawai perubatannya sebelum dirujuk pada defendan pertama dan kedua. Defendan-defendan adalah segelintir profesional wajib yang perlu ada jika responden hendak memberi perkhidmatan kecemasan secara rutin. Lebih penting lagi, tindakan cuai yang diadukan berlaku ketika jagaan dan rawatan diberi di dalam premis responden, menggunakan kemudahan dan perkhidmatannya; ini tidak berlaku di tempat lain. Berkaitan ciri ketiga dan keempat, amat jelas bahawa perayu tidak mempunyai kawalan atas bagaimana responden hendak melaksanakan fungsinya dalam memberi jagaan dan rawatan kecemasan; sama ada diberi secara kediri atau melalui pekerja-pekerjanya mahupun pihak ketiga seperti profesional-profesional yang diambil bekerja yang, pada mereka, diwakilkan fungsi penting rawatan dan jagaan pesakit-pesakit dalam perkhidmatan kecemasannya. Hakikatnya, sesudah menggalas kewajipan positif berhati-hati terhadap perayu dalam aspek perkhidmatan kecemasan, responden telah mewakilkan pada pegawai perubatannya, serta defendan pertama dan kedua, pelaksanaan kewajipannya dan individu-individu ini sememangnya menjalankan fungsi-fungsi yang diwakilkan tersebut. Berkaitan ciri kelima, tidak dinafikan bahawa defendan kedua cuai dalam pelaksanaan fungsi memberi jagaan dan rawatan wajar untuk kecemasan terhadap perayu, yang digalas tetapi diwakilkan padanya oleh responden. Oleh kerana kelima-lima ciri berjaya dipenuhi, responden ternyata mempunyai kewajipan berjaga-jaga yang tidak boleh diwakilkan, secara kediri, terhadap perayu. Pembelaan kontraktor bebas tidak boleh dipertahankan, bawah undang-undang, dan wajar ditolak oleh mahkamah bawahan.

(3) Akta terpakai pada semua kemudahan dan perkhidmatan jagaan kesihatan yang tidak diperuntukkan oleh Kerajaan melalui hospital atau institusi awam. Peruntukan-peruntukan Akta dan Perintah Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta (Hospital Swasta dan Kemudahan Jagaan Kesihatan Swasta Lain) 2006 meneguhkan lagi pemahaman bahawa hospital adalah, dan kekal, bertanggungjawab bukan sahaja demi keberkesanan premis atau kemudahan tetapi juga untuk rawatan dan jagaan pesakit-pesakit; tanpa mengira bagaimana atau pada siapa tanggungjawab tersebut diwakilkan. Ini adalah niat skema perundangan, hinggakan polisi hospital atau kemudahan dan perkhidmatan jagaan swasta dikehendaki diletakkan di tempat yang

mudah dilihat di premis, agar individu-individu yang datang ke hospital atau kemudahan dan perkhidmatan jagaan swasta sedar akan kewujudan polisi sedemikian. Tersirat dalam struktur dan skema perundangan ini keseimbangan dan penggabungan elemen-elemen keadilan, kesaksamaan dan kemunasabahan yang tidak perlu dipertimbangkan lagi sebagai langkah atau pertimbangan terasing.

(4) Perayu diawardkan ganti rugi kehilangan pendapatan seperti berikut: (i) ganti rugi khas berjumlah RM265,200, dikira berdasarkan daraban RM2,600 sebulan x pendarab 90 bulan; dan (ii) ganti rugi pra-perbicaraan, dikira berdasarkan daraban RM2,946 sebulan x pendaraban 30 bulan. Mahkamah Tinggi menetapkan RM2,600 sebulan sebagai daraban. Jumlah ini dikatakan tidak mengambil kira pendapatan perayu yang bersumberkan elaun, fi dan gaji bulanan yang dia terima sebagai pengarah syarikat yang cukainya sudah berbayar. Daraban tersebut hanya mengambil kira gaji asasnya. Mahkamah bawahan terkhilaf apabila tidak mengambil kira pendapatan-pendapatan ini dalam mengira daraban dan dalam mengambil kira daraban berbeza. Pendapatan-pendapatan ini, yang cukainya sudah berbayar, jelas terangkum dalam maksud 'pendapatan berdasarkan pekerjaan sendiri atau apa-apa aktiviti menguntungkan' bawah s. 28A Akta Undang-undang Sivil 1956 dan sepatutnya dipertimbangkan. Daraban pula haruslah selaras. Award yang sepatutnya adalah jumlah selaras RM8,750 sebulan dengan daraban-daraban yang dicadangkan oleh perayu. Tiada alasan untuk mengganggu penjalanan budi bicara mengawardkan faedah pada kadar 4% setahun untuk tempoh-tempoh relevan. Responden memohon satu perintah agar defendan kedua membayar ganti rugi responden jika responden didapati bertanggungan. Ini tidak betul dan tidak diperuntukkan oleh undang-undang kerana defendan kedua bukan pihak dalam rayuan ini dan, lebih penting lagi, amat bercanggah dengan dapatan-dapatan terdahulu bahawa responden mempunyai kewajipan berjaga-jaga yang tidak boleh diwakilkan dan kekal bertanggungan tanpa mengira siapa responden mengambil bekerja demi menjalankan kewajipan berjaga-jaga tersebut.

Oleh Zabariah Mohd Yusof HMP (menentang):

(1) Rayuan ini tergolong rapi bawah kategori termaktub kontraktor-kontraktor bebas. Tiada kesamaran dalam hubungan antara defendan kedua dan responden, dan ini terbukti melalui perjanjian residen dan pakar perunding. Tidak timbul isu perayu dinafikan remedi atau ganti rugi untuk tindakan cuai defendan kedua. Ini satu kes yang jelas dan mudah yang menunjukkan kontraktor bebas sebenar, yang tidak perlu menempuhi jalan berliku-liku dengan membangkitkan prinsip kewajipan berjaga-jaga yang tidak boleh diwakilkan demi membuat responden bertanggungan, sedangkan tindakan langsung remedi, menurut undang-undang tort, sudah tersedia buat mangsa.

(2) Pengenaan kewajipan berjaga-jaga yang tidak boleh diwakilkan bergantung padat pada fakta. Tuduhan-tuduhan luar rangkuman prinsip-prinsip termaktub, dalam menegaskan wujudnya kewajipan berjaga-jaga yang tidak boleh diwakilkan, perlu diteliti dengan cermat dan diguna pakai penuh beramaran, kerana kewajipan berjaga-jaga yang tidak boleh diwakilkan ini tidak sejajar dengan prinsip-prinsip berasaskan kesalahan dan adalah luar daripada kebiasaan. Dasar rangka kerja yang membentuk ciri-ciri penanda dalam *Woodland* mempunyai sekatan-sekatan dan kawalan-kawalan berat dan hanya terpakai dalam situasi luar biasa sebelum kewajipan tersebut boleh didapati sebagai kewajipan berjaga-jaga yang tidak boleh diwakilkan. Kriteria hubungan anteseden, kewajipan positif dan fungsi besar tinggi nilai ambangnya untuk dipenuhi. *Woodland* tidak meluaskan ruang lingkup kewajipan berjaga-jaga yang tidak boleh diwakilkan. Terdapat kekerapan dalam mencari defendan yang kaya, demi memuaskan tuntutan-tuntutan ganti rugi, sambil bertopengkan kewajipan berjaga-jaga yang tidak boleh diwakilkan, sedangkan terdapat kes nyata seorang kontraktor bebas atau hubungan majikan-pekerja, dan ini satu perkembangan yang membimbangkan. Dalam rayuan ini, responden memberi perkhidmatan kesihatan kritikal dan perayu terlebih dahulu menerima rawatan di hospital lain dan dibawa ke responden susulan situasi kritikal dan kecemasan serta situasi hidup-atau-mati. *Woodland* memberi amaran tentang penyangkutan beban-beban berat, yang tidak munasabah, terhadap pihak-pihak yang memberi perkhidmatan awam dan kewajipan berjaga-jaga yang tidak boleh diwakilkan harus dikenakan setakat yang adil, saksama dan munasabah. Apabila kriteria rangka kerja sudah dipenuhi, pengenaan kewajipan berjaga-jaga yang tidak boleh diwakilkan tidak akan menimbulkan beban yang tidak munasabah. Walau bagaimanapun, ini tidak berlaku dalam kes ini.

(3) Amaran harus diingatkan apabila mahkamah meluaskan ruang lingkup tanggungan pihak-pihak yang bukan pelaku tort (apabila mahkamah meluaskan ruang lingkup liabiliti vikarius). Ini adalah wilayah polisi, satu wilayah yang mahkamah tidak arif dan jika kewajipan sedemikian harus diluaskan dan dikenakan pada hospital-hospital swasta atau institusi-institusi perubatan seperti responden, adalah bijak jika semuanya diperuntukkan oleh undang-undang kerana ini akan memberi kesan pada institusi-institusi perubatan dan profesyen perubatan yang adalah kontraktor-kontraktor bebas, yang secara tekniknya tidak dikawal pelaksanaan kewajipan perubatan mereka oleh hospital-hospital seperti responden.

(4) Doktrin kewajipan berjaga-jaga yang tidak boleh diwakilkan tidak terpakai dalam situasi fakta rayuan ini. Rayuan ditolak dengan kos. Mahkamah Tinggi dan Mahkamah Rayuan tidak terkhilaf dalam

menolak tuntutan perayu terhadap responden. Tiada kewajipan berkanun yang dikenakan pada responden yang membuatkannya bertanggungan atas kecuaian seorang pengamal perubatan berdaftar yang juga adalah kontraktor bebas dan bukan pekerja hospital.

Case(s) referred to:

AJS v. JMH & Another Appeal [2022] 1 CLJ 331 FC ***(refd)***
Armes v. Nottinghamshire County Council [2017] UKSC 60 ***(refd)***
Armes v. Nottinghamshire County Council [2018] 1 All ER 1 ***(refd)***
Breakingbury v. Croad [2021] Med LR 509 ***(refd)***
Bursa Malaysia Securities Bhd v. Mohd Afrizan Husain [2022] 4 CLJ 657 FC ***(refd)***
BXB v. Trustees Of The Barry Congregation of Jehovah's Witnesses And Another [2023] 3 All ER 1 ***(refd)***
Cassidy v. Ministry Of Health [1951] 2 KB 343 ***(refd)***
Cassidy v. Ministry Of Health, Roe v. Minister Of Health [1954] 2 QB 66 ***(refd)***
Chai Beng Hock v. Sabah Medical Centre Sdn Bhd & Ors [2011] CLJU 33; [2011] 1 LNS 33 HC ***(refd)***
Cox v. Ministry Of Justice [2016] UKSC 10 ***(refd)***
Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor And Another Appeal [2018] 3 CLJ 427 FC ***(refd)***
Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal [2017] 10 CLJ 529 FC ***(refd)***
Farraj v. King's Healthcare NHS Trust [2009] EWCA Civ 1203 ***(refd)***
GB v. Home Office [2015] EWHC 819 ***(refd)***
Gold v. Essex County Council [1942] 2 KB 293 ***(refd)***
Gulf View Medical Centre Ltd v. Tesheira (The Executrix Of The Estate Of Russell Tesheira) (Trinidad And Tobago) & Another Appeal [2022] UKPC 38 ***(refd)***
Hemraj & Co Sdn Bhd v. Tenaga Nasional Bhd [2023] 1 CLJ 651 FC ***(refd)***
Henderson v. Merret Syndicates Ltd, Hallam-Eames v. Merrett Syndicates Ltd, Hughes v. Merret Syndicates Ltd, Arbuthnott v. Feltrim Underwriting Agencies Ltd, Deeny v. Gooda Walker Ltd (In liq) [1994] 3 All ER 506 ***(refd)***
Hii Chii Kok v. Ooi Peng Jin London Lucien [2016] 2 SLR 544 ***(refd)***
Hillyer v. The Governors Of St Bartholomew's Hospital [1909] 2 KB 820 ***(refd)***
Holliday v. National Telephone Co [1899] 2 QB 392 ***(refd)***
Home Office v. Dorset Yacht Co Ltd [1970] 2 All ER 294 ***(refd)***
Honeywill v. Larkin [1934] 1 KB 191 ***(refd)***
Hughes v. Rattan [2022] EWCA Civ 107 ***(refd)***
Hughes v. Rattan [2023] 1 All ER 300 ***(refd)***
Kondis v. State Transport Authority (1984) 154 CLR 672 ***(refd)***
Koperasi Rakyat Bhd v. Harta Empat Sdn Bhd [2000] 3 CLJ 719 FC ***(refd)***
Management Corporation Strata Title Plan No 3322 v. Tiong Aik Construction Pte Ltd & Anor [2016] SGCA 40 ***(refd)***
Mohamud v. WM Morrison Supermarkets plc [2016] UKSC 11 ***(refd)***
Myton v. Wood (1980) 79 LGR 28 ***(refd)***
New South Wales v. Lepore (2003) 212 CLR 511 ***(refd)***
Ng Huat Seng v. Munib Mohammad Madni [2017] SGCA 58 ***(refd)***
Roe v. Minister Of Health [1954] 2 QB 66 ***(refd)***
Rylands v. Fletcher [1866] LR 1 Exch 265 ***(refd)***

Smith v. Baird & Co Ltd [1940] AC 242 ***(refd)***
Tan Kah Fatt & Anor v. Tan Ying [2023] 2 CLJ 169 FC ***(refd)***
Various Claimants v. Institute Of Brothers Of The Christian Schools [2013] 1 All ER 670 ***(refd)***
Vincent Manickam David (Suing By Himself & As Administrator Of The Estate Of Catherine Jeya Sellamah, Deceased) & Ors v. Dr S Hari Rajah & Anor [2017] 8 CLJ 27 CA ***(refd)***
White v. Jones [1995] 1 All ER 691 ***(refd)***
Wilsons & Clyde Coal Co Ltd v. English [1938] AC 57 ***(refd)***
Woodland v. Essex County Council [2013] UKSC 66 ***(refd)***
Woodland v. Essex County Council [2014] 1 All ER 482 ***(refd)***
Woodland v. Swimming Teachers Association & Others [2014] AC 537 ***(refd)***
X & Ors (Minors) v. Bedfordshire County Council; M (A Minor) & Anor v. Newham London Borough Council & Ors; E (Minor) v. Dorset County Council & Other Appeals [1995] 3 All ER 353 ***(refd)***

Legislation referred to:
Civil Law Act 1956, s. 28A(2)(c)(i), (d)(ii)
Courts of Judicature Act 1964, s. 96
Interpretation Acts 1948 and 1967, s. 17A
Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006, regs. 11(4), 13, 21, 22, 23, 24, 25, 26, 27, 230(3), (8), (9), 231(12)
Private Healthcare Facilities and Services Act 1998, ss. 2, 3, 4, 5, 6, 31(1)(d), 35(2), 38(1), 74, 75, 78, 108

For the appellant - PS Ranjan, Manmohan Singh Dhillon, KB Karthi & Desmond Mun; M/s PS Ranjan & Co
For the respondent - Ambiga Sreenevasan, Janini Rajeswaran, T Tharumarajah & Amos Siew; M/s Azim, Tunku Farik & Wong
For the amicus curiae (Persatuan Hospital Swasta Malaysia) - Malik Imtiaz Sarwar, Khoo Suk Chyi, Felix Raj & Joseph Lum
For the amicus curiae (Persatuan Pengguna Pulau Pinang) - Gurdial Singh Nijar, Jessica Ran Binwani & Abraham Au Tian Hui; M/s Kanesh Sundrum & Co

[Editor's note: Appeal from Court of Appeal; Civil Appeal No: B-02(NCVC)(W)-1175-09-2020 (overruled); Appeal from High Court; Suit No: 23NCVC-27-10-2017 (overruled).]

Reported by Najib Tamby

JUDGMENT

Mary Lim FCJ (majority):

[1] This is the majority decision of the court. My learned brothers, Mohamad Zabidin bin Mohd Diah CJM and Abdul Rahman bin Sebli CJSS, and my learned sister Hasnah binti Mohammed Hashim FCJ have read this judgment in draft and have agreed with the said draft.

[2] The appellant instituted a claim through his wife as he had suffered severe brain damage as a result of treatment rendered by the first and second defendants, medical specialists who practised at a hospital managed or

operated by the respondent, the third defendant at the High Court. After a full trial, the claim against the second defendant was allowed while the claims against the first and third defendants were dismissed. That decision on liability was sustained on appeal although appeal on quantum was allowed and the amount was varied to some extent by the Court of Appeal. Being dissatisfied, the appellant sought leave to appeal.

[3] On 14 February 2023, leave was granted on the following seven questions of law:

(i) whether the owner and manager of a hospital is in law a provider of healthcare and owes a non-delegable duty of care to patients as stated by the English Court of Appeal in the post-*Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal* [2017] 10 CLJ 529; [2018] 1 MLJ 685 case of *Hughes v. Rattan* [2022] EWCA Civ 107?

(ii) whether the judgment of the Federal Court in *Dr Kok Choong Seng* regarding the tort of negligence in a private hospital applies where the owner and manager of the hospital owes separately duties of care in contract and by statute?

(iii) whether the owner and manager of a private hospital is liable to patients under a non-delegable duty of care when a doctor practising in the hospital as an independent contractor has insufficient professional indemnity for malpractice?

(iv) if the answer is yes, whether the owner and manager, as a provider of healthcare, may escape liability for a breach of such duty of care committed by a doctor because the doctor is an independent contractor who has been engaged to practise in the hospital?

(v) whether there is a statutory duty of care, independent of a duty in negligence or contract, owed by the owner and manager of a private hospital under the Private Healthcare Facilities and Services Act 1998 and the subsidiary legislation made thereunder?

(vi) whether the fees received by a director of a company from the company are 'earnings by his own labour or other gainful activity' under s. 28A(2)(c)(i) of the Civil Law Act 1956?

(vii) in light of the post-*Dr Kok Choong Seng* case of *Armes v. Nottinghamshire County Council* [2018] 1 All ER 1 decided by the Supreme Court of the United Kingdom, whether after applying the five-feature test in *Woodland v. Essex County Council* [2014] 1 All ER 482, a court must additionally apply the test of whether it is fair, just and reasonable to impose a non-delegable duty of care in the circumstances of the case?

[4] Following the grant of leave, the appellant filed a notice of appeal appealing against the decision dismissing the claim against the respondent, and in respect of quantum, for having failed to take into consideration the fees earned as director.

[5] The focus in this appeal is in respect of the liability of the respondent; the other defendants at the High Court are not parties to this appeal. Aside from question (vi) which deals with the calculation of damages, all the other questions pertain to the issue of whether a private hospital may be liable for the tort of a medical practitioner who is said to be an independent contractor. In short, whether such an entity itself owes an independent duty which is non-delegable, regardless to whom it may have delegated that duty to, irrespective of who may have performed the act or omission complained of, whether under a contract for service or due to the patient's own choice.

[6] This question was substantially addressed in *Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal* [2017] 10 CLJ 529; [2018] 1 MLJ 685; [2017] 6 MLRA 367. However, due to certain developments under English law, which was to a large extent, followed in that decision, we are now invited to revisit this area of jurisprudence.

Factual Background

[7] The appellant had undergone a tonsillectomy, palatal stiffening and endoscopic sinus surgery at the Subang Jaya Medical Centre (SJMC) on 10 March 2010. At about 3.30am on 22 March 2010, the appellant suffered bleeding at the site of the operation. He was brought to the Accident and Emergency Department of the respondent by his family. As mentioned earlier, the respondent is a private hospital.

[8] At the respondent's Emergency Department, the appellant was examined by a medical officer who then called the first defendant, a consultant ear, nose and throat surgeon. The first defendant recommended that the appellant undergo an examination under anaesthesia and wound debridement under general anaesthesia. The second defendant was the consultant anaesthetist who attended to the appellant.

[9] The appellant experienced complications even before surgery started. In the airlock area outside the operating theatre, he started vomiting copious amounts of blood and there was profuse bleeding. Despite efforts by the first and second defendants, the appellant collapsed and emergency resuscitation had to be executed. Thereafter, the intended surgery was performed. It was uneventful. Unfortunately, the appellant suffered hypoxic brain damage. After surgery, he was admitted to the Intensive Care Unit of the respondent for continued post-surgical care and management. At the family's request, the appellant was transferred out to SJMC on 28 March 2010. He is now permanently mentally and physically disabled by reason of the massive cerebral hypoxia.

[10] Through his wife, the appellant initiated a suit against the two consultants and the respondent. The suit is founded in contract and in tort, for negligence; and for breach of duties under the Private Healthcare Facilities and Services Act 1998. At para. 29 of the statement of claim, the appellant alleged that the respondent is "vicariously liable for the negligence of the first and second defendants and is also directly liable for breach of its non-delegable duty".

[11] All the allegations were denied. In particular, the respondent pleaded that the first two defendants carried out their respective medical practice at its hospital as independent contractors under contracts for services. As such, all diagnoses, medical advice, including material risks and known complications, medical treatments, operations and referrals are the responsibility of these defendants. The respondent averred that its responsibility as owners and managers of the hospital was "merely to ensure the provision of facilities and medical equipment, including nursing staff".

Decisions Of The High Court And Court Of Appeal

[12] The learned trial judge dismissed the claim against the first defendant because "from the evidence as a whole, the plaintiff had simply failed to establish any causal link between D1's acts and/or omission and the injuries that he suffered. His brain damage had no connection with any intervention or alleged failure to intervene by D1 … the acts or omissions complained of did not amount to negligence that would warrant a finding or apportionment of liability against D1".

[13] On the other hand, the learned trial judge found against the second defendant; that there were "indisputably other emergency, life-saving procedures which D2 in line with expert opinion, ought to have considered but she failed to do so. Importantly, she did not even discuss the said options, which were within her purview and professed expertise, with D1". From His Lordship's analysis of the facts, opinions and evidence material to the issues in dispute, His Lordship was satisfied that "negligence ought to be ascribed to D2 as it had become plainly obvious that her conduct had fallen below the standard of skill and care expected from an ordinary competent doctor professing the relevant specialist skills based on which she was entrusted to treat the plaintiff".

[14] As for the respondent, the High Court found that the appellant "had failed to adduce any credible, let alone sufficient, evidence to prove the above particulars of negligence against D3". On the issue of vicarious and direct non-delegable duty, the learned judge found that the first and second defendants were "at all material times not as employees, servants or agents of the hospital but as independent contractors … Their contracts were evidenced by the resident and consultant agreements produced in court". According to the High Court, the appellant "seemed to admit in his pleadings

that D1 and D2 had held themselves as independent contractors. Hence, he could not now contend that there was a private agreement or arrangement between them and D3 without the knowledge of the patient". Aside from those observations, there were really not much deliberations on this question of whether the respondent owed a non-delegable duty to the appellant which duty was breached when there was negligence found on the part of the second defendant.

[15] Both the appellant and the second defendant appealed. The appellant's appeal was in respect of all the defendants and also on the matter of quantum.

[16] At the Court of Appeal, the appeal against the respondent was dismissed whereas the appeal in respect of quantum was allowed in part, as against the second defendant. The appellant withdrew the appeal against the first defendant. The second defendant's appeal was dismissed.

[17] The appeal now concerns the respondent alone.

Analysis And Determination

[18] The appellant's claim against the respondent is premised on the existence of a non-delegable duty of care; that the respondent had breached that duty as well as its contractual, statutory and/or other duties. The appellant further claimed that the respondent was vicariously liable for the second defendant's tort. The argument on vicarious liability was abandoned at the Court of Appeal and it is no longer an issue in this appeal. The law in this respect was however discussed in the Court of Appeal decision of *Vincent Manickam David (Suing By Himself & As Administrator Of The Estate Of Catherine Jeya Sellamah, Deceased) & Ors v. Dr S Hari Rajah & Anor* [2017] 8 CLJ 27; [2018] 2 MLJ 497; [2017] 5 MLRA 244 – see paras. 26 to 75.

[19] Further discussions may be found in the Federal Court decisions of *Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal* (*supra*), and *Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor And Another Appeal* [2018] 3 CLJ 427; [2018] 3 MLJ 281; [2018] 1 MLRA 535. Also, see *Mohamud v. WM Morrison Supermarkets plc* [2016] UKSC 11, [2017] 1 All ER 15; *X & Ors (Minors) v. Bedfordshire County Council; M (A Minor) & Anor v. Newham London Borough Council & Ors; E (Minor) v. Dorset County Council & Other Appeals* [1995] 3 All ER 353; *BXB v. Trustees Of The Barry Congregation Of Jehovah's Witnesses And Another* [2023] 3 All ER 1; and *Armes v. Nottinghamshire County Council* [2018] 1 All ER 1. The two principles are distinct and discrete, though frequently deployed to the same set of facts in order to find some measure of liability in tort. That, however, is for another occasion.

[20] In this appeal, the central issue is whether the respondent owes a non-delegable duty of care to the patient, the appellant. The Private Healthcare Facilities and Services Act 1998 (Act 586) and the Regulations

made thereunder are relied on to amplify and support the contention that such a duty of care exists in law and was established on the facts; in which case, the questions must be answered in the appellant's favour and the appeal allowed.

[21] This issue has become particularly important given the proliferation and burgeoning of private hospitals or private healthcare, seen now almost as a necessary and vital complement to the public hospital system. The growth of such private hospitals or private healthcare is not confined to the capital city but can be readily seen in many of our larger towns. It may even be said that one is spoilt for choice when it comes to such care and facility. It is also now offered as a tourist package or health tourism, as described by *amicus curiae* for the Association of Private Hospitals of Malaysia.

[22] In Malaysia, private hospitals are said to "alleviate the public healthcare system by providing an alternative to patients to seek appropriate healthcare as they see fit and because of their access to resources, are also said to be able to act as standard setters as they are able to employ new technologies and implement measures for efficient delivery of care to patients". With the added dimension of complex corporate venture structures as most of these private hospitals are operated and managed, this issue of liability of those who manage and operate these hospitals or healthcare facilities in relation to the medical practitioners who practice within these establishments through some contractual arrangement or other but who are the persons actually rendering the healthcare and treatment to patients, becomes rather acute and urgent.

(i) The Principle Of Non-delegable Duty Of Care

[23] The appellant's claim is grounded on the tort of negligence. It is fault-based which means the tort, wrongdoing or omission complained of is committed by the tortfeasor and the claim is brought against that tortfeasor personally. Ordinarily, the law does not impose a personal liability for what others do or fail to do. This principle is however displaced with the imposition of liability on this other person or entity under certain conditions or circumstances; this liability is more conventionally known as a non-delegable duty of care.

[24] This principle, particularly in the field of medical negligence or in certain jurisdictions known as the law on bioethics, is not new to our jurisdiction. In *Dr Kok* (*supra*) (*Dr Kok*), the Federal Court recognised and adopted this principle of non-delegable duty of care as propounded in *Woodland v. Swimming Teachers Association & Others* [2014] AC 537 (*Woodland*). Shortly after, the Federal Court revisited the issue in *Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor & Another Appeal* (*supra*) (*Dr Hari Krishnan*). Both decisions concerned claims of medical negligence and the liability of the private hospitals where the events took place were scrutinised. Recently, this court once again revisited this principle

in the case of *Hemraj & Co Sdn Bhd v. Tenaga Nasional Bhd* [2023] 1 CLJ 651; [2023] 1 MLJ 785; [2023] 2 MLRA 25 (*Hemraj*), this time in respect of dangerous or hazardous works. In all these cases, the defence was primarily that the tortfeasor is an independent contractor for which the defendant was not liable, vicariously or directly. The latter expression of direct liability is where the term, non-delegable duty is generally or commonly used.

[25] Despite these pronouncements, it appears the law on non-delegable duty or rather its application, remains challenging in various respects, especially in medical negligence claims against private hospitals. Perhaps, the process of distinction described by Lady Hale may have failed to "make sense to ordinary people" (see *Woodland*, [29]). Leave was thus granted under s. 96 of the Courts of Judicature Act 1964 (Act 91); more so to determine if there is any change or development in the light of some recent decisions in this regard in the UK.

[26] In the light of *Dr Kok* and *Dr Hari Krishnan*, it is timely to take stock of where the law is in this regard; to see if common law as "a dynamic instrument" needs to develop and adapt to meet the new situations presented in this appeal; or must we proceed with caution, incrementally by analogy with existing categories and consistently with some underlying principle as cautioned by Lady Hale in *Woodland*. Further, as opined by the Supreme Court in *Armes v. Nottinghamshire County Council* [2018] 1 All ER 1, 13, para. [36], "the criteria articulated by Lord Sumption may need to be re-considered or possibly refined, in particular contexts".

[27] It must be emphasised that for this principle of non-delegable duty to have any relevance and impact on the outcome of the appeal, it must first be shown the presence of negligence. That, is not an issue in this appeal. The High Court found the second defendant negligent and those findings have been affirmed on appeal.

[28] Back to the principle of non-delegable duty of care. First, to understand what that principle entails. Lord Sumption in *Woodland* opined that there is no "single theory" on when or why there is this principle of non-delegable duty of care. Nevertheless, there are helpful discussions on the principle in *Dr Kok* and in the recent decision of *Hemraj*. Both decisions return to *Woodland* although in *Hemraj*, the discussion took a slightly different course as the facts concerned the first of the two broad categories of case in which such a duty has been held to arise, as identified by Lord Sumption in *Woodland*. That category being those cases where an independent contractor is engaged to perform some function which is either inherently hazardous or liable to be so in the course of the work. Incidentally, the law appears to have first developed in this type of cases – see *Hemraj*.

[29] It is however, the second category which is of concern in this appeal. Again, I turn to Lord Sumption who explained that:

> [7] The second category of non-delegable duty is, however, directly in point. It comprises cases where the common law imposes a duty upon the defendant which has three critical characteristics. *First, it arises not from the negligent character of the act itself but because of an antecedent relationship between the defendant and the claimant. Second, the duty is a positive or affirmative duty to protect a particular class of persons against a particular class of risks, and not simply a duty to refrain from acting in a way that foreseeably causes injury. Third, the duty is by virtue of that relationship personal to the defendant.* The work required to perform such a duty may well be delegable, and usually is. But the duty itself remains the defendant's. Its delegation makes no difference to his legal responsibility for the proper performance of a duty which is in law his own. In these cases, the defendant is assuming a liability analogous to that assumed by a person who contracts to do work carefully. The contracting party will normally be taken to contract that the work will be done carefully by whomever he may get to do it: *Photo Production Ltd v. Securicor Transport Ltd* [1980] 1 All ER 556 at 566, [1980] AC 827 at 848 (Lord Diplock). (emphasis added)

[30] Here, Lord Sumption identified the first three characteristics where the law imposes a non-delegable duty of care: the antecedent relationship between the plaintiff and the defendant; a positive or affirmative duty to protect a particular class of persons against a particular class of risks; and the relationship is personal to the defendant. These three characteristics were later developed into and formed part of the five defining features, more commonly known as the "*Woodland* features".

[31] Lord Sumption identified the genesis of the principle of non-delegable duty, traced it from the law of nuisance to the present state where it is generally invoked to impose an assumption of responsibility in situations "where by virtue of some special relationship, the defendant is held to assume positive duties"; that the classic example is "a duty to perform professional services arising out of a special relationship equivalent to contract but not contractual" (see *Henderson v. Merret Syndicates Ltd, Hallam-Eames v. Merrett Syndicates Ltd, Hughes v. Merret Syndicates Ltd, Arbuthnott v. Feltrim Underwriting Agencies Ltd, Deeny v. Gooda Walker Ltd (In liq)* [1994] 3 All ER 506, [1995] 2 AC 145); whilst another example would be where there is a sufficient degree of dependence, or even non-reliance as in *Home Office v. Dorset Yacht Co Ltd* [1970] 2 All ER 294; [1970] AC 1004; *White v. Jones* [1995] 1 All ER 691. Lord Sumption then noted that this principle had been considered in a number of cases involving employees, hospital patients, school pupils and invitees, where the negligent act was by a person for whom the defendant is not vicariously liable. Each of those categories was then discussed together with Australian case law before His Lordship opined that the "time has come to recognise that Lord Greene in *Gold v. Essex CC* and Denning LJ in *Cassidy v. Ministry Of Health* were correct in identifying the underlying principle".

[32] It is that underlying principle in respect of the second category of cases which was given a framework by Lord Sumption. In His Lordship's opinion, a non-delegable duty will arise if the following defining features are present:

(a) the claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury;

(b) there is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, which:

(a) places the claimant in the actual custody, charge or care of the defendant, and

(b) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren;

(c) the claimant has no control over how the defendant chooses to perform those obligations; *ie*, whether personally or through employees or through third parties;

(d) the defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant, and the third party is exercising for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it;

(e) the third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

[33] These five defining features, generally referred to as the five *Woodland* features, incorporate the three critical characteristics earlier mentioned.

[34] This court in *Dr Kok* explained the principle of non-delegable duty of care in the following terms:

> [36] *The nature of a non-delegable duty is, in essence, a positive duty to ensure that reasonable care is taken.* Viewed in its proper context thus, non-delegable duties are not an anomaly in the law of negligence without a common basis, but founded on established concepts rooted in the general principles of the law of negligence itself. *An assumption of responsibility may be inferred from the creation of a special risk, or a special antecedent relationship between him and the claimant.* The assumption of responsibility gives rise to a positive duty to protect the claimant from harm, and forms the rationale for

imposing a more onerous duty of care on the defendant. Indeed, the concept of assumption of responsibility has been posited as the unifying basis that may serve to explain both Lord Sumption's first and second categories of cases (see J Murphy, *Juridical foundations of common law non-delegable duties* in JW Neyers *et al*, *Emerging Issues in Tort Law* (Oxford: Hart, 2007)).

[37] *The defining features, including the claimant's vulnerability or dependence and the defendant's control or custody over the claimant, are factors well-recognised to require a higher standard of care.* Where a particular combination of such factors (as identified by Lord Sumption) exists, the standard of care is exceptionally heightened so that the requirement of reasonable care is not met simply by delegating the function to a competent contractor, but by ensuring that due care is exercised in the performance of that function by whomever is appointed to do so. However, liability for breach of a non-delegable duty does not amount to strict liability for any injury or damage caused in the performance of that function. The duty is discharged as long as reasonable care is taken by the delegatee (see *Roe v. Minister of Health* [1954] 2 QB 66).

[38] *Non-delegable duties have been erroneously considered as a 'kind of vicarious liability',* and adopted as part of the test to determine vicarious liability in some cases. This is a misconception. The two doctrines are similar in effect, in that they both result in liability being imposed on a party (the defendant) for the injury caused to a victim (the plaintiff) as a result of the negligence of another party (the tortfeasor). However, it bears emphasis that non-delegable duties and vicarious liability are distinct in nature and basis. The former imposes personal liability on the defendant for the breach of his own duty towards the plaintiff, based on the relationship between the defendant and the plaintiff, regardless of whom the defendant has engaged to perform the task. The latter imposes vicarious liability on the defendant for the tortfeasor's breach of duty towards the plaintiff, based on the relationship of employment between the defendant and the tortfeasor.

[39] The doctrine of non-delegable duties has an independent scope of application apart from the realm of vicarious liability. A number of scenarios illuminate the distinction. Non-delegable duties, or positive duties to ensure that reasonable care is taken, may exist in situations where there is no vicarious liability: for instance where harm is caused as a result of a system failure and no individual tortfeasor can be identified, or where harm is caused by a third party to a plaintiff under the defendant's custody. Conversely, vicarious liability can operate in the absence of a non-delegable duty, in cases where the elements of a special hazard or a relationship of vulnerability or dependence are absent (*eg,* an employee who negligently hits a pedestrian, while driving a vehicle in the course of employment). The two doctrines are conceptually and practically distinct. (emphasis added)

[35] Thus, the principle of non-delegable duty is actually "founded on established concepts rooted in the general principles of the law of negligence itself. An assumption of responsibility gives rise to a positive duty to protect the claimant from harm, and forms the rationale for imposing a more onerous duty of care on the defendant". The obligation or liability is imposed because of the existence of an antecedent relationship between the parties apart from that between the plaintiff and the tortfeasor(s). The duty that is imposed is a positive duty to protect the plaintiff who is of a particular class against particular risks. That duty arises because of the relationship which is personal to the defendant. Under these conditions, such a defendant is treated in law as having assumed responsibility for the exercise of due care by anyone to whom he may delegate its performance.

[36] In *Dr Kok*, this court had added that because non-delegable duties impose more onerous obligations, it would heed the 'proviso in *Woodland*', that such duty should only be imposed where it is fair, just and reasonable to do so based on the particular circumstances of the case, and developed incrementally from existing categories and consistently with underlying principles (see para. [40]). This was reiterated in *Dr Hari Krishnan*, para. [142].

[37] I will address this 'proviso in *Woodland*' shortly, but first, it is important to bear in mind that *Woodland* was not a case of medical negligence where a private hospital was sued on the ground that it owed a non-delegable duty to its patients. This aspect is relevant as it explains some of the remarks and observations made by both Lord Sumption and Lady Hale in the course of their respective reasonings. That was a case where the appellant, a young pupil at a school managed by the respondent education authority, sustained serious brain injury as a result of a swimming mishap. Both the swimming teacher and the lifeguard on duty at the pool where the lessons were being conducted were not employed by the respondent, the former being an independent contractor who had contracted with the education authority to provide swimming lessons to its pupils. The issue was whether the respondent owed the appellant a non-delegable duty of care which, if answered in the affirmative, meant that the respondent was liable for the negligence of the swimming teacher and the lifeguard.

[38] In adopting the *Woodland* features, this court in both *Dr Kok* and *Dr Hari Krishnan* set about applying the five features to the particular facts of the case. Having done that, the Federal Court in *Dr Kok* found the second feature not met whilst in *Dr Hari Krishnan*, this court found all five features present in respect of Dr Namazie, the anaesthetist but not in respect of Dr Hari. This court further found the hospital not vicariously liable for both specialists, that both were independent contractors.

[39] In its penultimate analysis, this court in *Dr Kok* touched on the issue of whether private hospitals should or should not generally be held liable for the negligence of their doctors. This court refrained from making a broad pronouncement on the liability of all private hospitals in medical negligence cases on the basis of policy alone as it would "risk over-generalising the nuances of modern business relationships, and result in an unprincipled approach to liability". Has this changed? In this regard, I heed back to my earlier remarks of the observations of Lord Reed in *Armes*, that the criteria or five features "may need to be re-considered or possibly, refined in the particular contexts".

(ii) Proviso In Woodland

[40] Here, I return to the matter of the 'proviso in *Woodland*'; that a non-delegable duty should only be imposed only so far as it would be fair, just and reasonable to do so. This so-called 'proviso' was remarked by Lord Sumption after citing several decisions which had rejected the imposition of a non-delegable duty in the particular facts. According to Lord Sumption:

> [25] The courts should be sensitive about imposing unreasonable financial burden on those providing critical public services. A non-delegable duty should be imputed to schools only so far as it would be fair, just and reasonable to do so.

[41] His Lordship then proceeded to offer at least six reasons why he did not "accept that any unreasonable burden would be cast on them by recognising the existence of a non-delegable duty on the criteria which I have summarised above". The "criteria" being the five defining features while the "them" refers to the school authorities.

[42] In my view, this so-called proviso does not arise and has in fact been misunderstood. When Lord Sumption suggested that the imposition of non-delegable duty should only be where it would be fair, just and reasonable, His Lordship was actually referring to the context of that appeal where the local authority in question and the like were providing "critical public services". In that context, His Lordship cautioned the need for the courts to be sensitive about imposing unreasonable financial burdens. This is borne out by the six reasons offered; that "schools are employed to educate children, which they can do only if they are allowed authority over them … when the school's own control is delegated to someone else for the purpose of performing part of the school's own educational function, it is wholly reasonable that the school should be answerable for the careful exercise of its control by the delegate … that schools provide a service either by contract or pursuant to a statutory obligation, and while LEA schools do not receive fees, their staff and contractors are paid professionals".

[43] When Lady Hale's supporting judgment is examined, it will be seen that Her Ladyship agreed with Lord Sumption but did not repeat that same "proviso", opining that "recognising the existence of a non-delegable duty in the circumstances described above would not cast an unreasonable burden upon the service providers for all the reasons that he gives". Instead, Lady Hale's subjected her agreement to the principle to apply in the circumstances described by Lord Sumption subject to the "usual provisos that such judicial statements are not to be treated as if they are statutes and can never be set in stone". Her Ladyship took pains to explain that there should be no distinction between parents who paid for their children's education and those who do not; that "In the context of a necessary service, such as education, this does not seem a compelling distinction … All three girls have at least these features in common: (i) they have to go to school – their parents may be criminally liable if they do not and in extreme cases they may be taken into care if they refuse to go to school; (ii) when at school they have to do as the teachers and other staff say, with various sanctions if they do not; (iii) swimming lessons are part of the curriculum which the school has undertaken to provide; (iv) neither the children nor their parents have any control or choice about the precise arrangements made by the school to provide them with swimming lessons; (v) they are all young people who need care and supervision (as well as to be taught how to swim) for their own safety".

[44] At para. [34], Lady Hale in fact compared the situation of the appellant child with a patient at a hospital, explaining that "the reason why the hospital or school is liable is that the hospital has undertaken to care for the patient, and the school has undertaken to teach the pupil, and that the responsibility is not discharged simply by choosing apparently competent people to do it. The hospital or school remains personally responsible to see that care is taken in doing it".

[45] I find further support from Lord Reed's observations in *Armes* (*supra*), that the question arises actually in relation to vicarious liability and not, non-delegable duty:

> [36] … That does not, however, mean that it is routinely necessary for the judge to determine what would be fair and just as a second stage of the analysis. As was made clear by this Court in *Cox v. Ministry of Justice* [2016] UKSC 10, [2017] 1 All ER 1, [2016] AC 660 (para [41]), in relation to vicarious liability, having recourse to a separate inquiry into what is fair, just and reasonable is not only unnecessarily duplicative, but is also apt to give rise to uncertainty and inconsistency.

[46] What is the position in Singapore? It differs slightly. In *Management Corporation Strata Title Plan No 3322 v. Tiong Aik Construction Pte Ltd & Another* [2016] SGCA 40, while it expressed approval of the five *Woodland* features, the Singapore Court of Appeal said:

> In our judgment, moving forward, to demonstrate that a non-delegable duty arises on a particular set of facts, a claimant must minimally be able to satisfy the court either that; (a) the facts fall within one of the established categories of non-delegable duties; or (b) the fact possess all the features described at [58] above [the five defining features in *Woodland*]. However, we would hasten to add that (a) and (b) above merely lay down threshold requirements for satisfying the court that a non-delegable duty exist – the court will additionally have to take into account the fairness and reasonableness of imposing a non-delegable duty in the particular circumstance, as well as the relevant policy considerations in our local context.

[47] It would appear that Singapore does not require the satisfaction of the *Woodland* features in every case; and even then, the requirements are only a "threshold" with fairness and reasonableness and "relevant policy considerations" seen as additional matters to be taken into account. Care however, must be exercised as this pronouncement was not in the context of a medical negligence case. Similarly, the decision in *Ng Huat Seng v. Munib Mohammad Madni* [2017] SGCA 58. Both cases actually are of the first broad category of cases, like *Hemraj* (*supra*). The position in relation to healthcare is still left open and not decided since negligence was not established on the facts. At the High Court however, the existence of a non-delegable duty of care was rejected because of Singapore's statutory regime – see *Hii Chii Kok v. Ooi Peng Jin London Lucien* [2016] 2 SLR 544.

[48] Consequently, the imposition of this fair, just and reasonable condition in the second category of cases concerning medical negligence does not arise. In any case, the respondent in this appeal is not rendering a public service as used and understood in the English cases, reliant on public funds through the system of taxation or voluntary contributions. It is a private business entity set up for the specific purpose of rendering private healthcare facilities and services; quite clearly for profit. When the statutory regime governing private healthcare facilities and services is scrutinised, this becomes even clearer. This statutory framework actually forms or creates the necessary relationship for which a non-delegable duty of care may be deemed to have been assumed.

[49] In the context of private hospitals, and for the added reasons to follow, the rationale of any non-delegable duty owed by such hospitals is quite well-put by Lord Dyson LJ in *Farraj v. King's Healthcare NHS Trust* [2009] EWCA Civ 1203; (2009) 111 BMLR 131; [2010] 1 WLR 2139:

> … the hospital undertakes the care, supervision and control of its patients who are in a special need of care. Patients are a vulnerable class of persons who place themselves in the care and under the control of a hospital and as a result, the hospital assumes a particular responsibility for their well-being and safety.

[50] Going back to *Dr Kok*, this court had also found favour with similar *obiter* statements made in several decisions. First, the view expressed by Lord Greene MR in *Gold v. Essex County Council* [1942] 2 KB 293, that once the extent of the obligation assumed by a defendant hospital is discovered, he cannot escape liability because he has employed another, whether as servant or agent to discharge it on his behalf; that the hospital's duty is not confined to administrative matters, providing proper facilities and selecting competent staff:

> When a patient seeking free advice and treatment such as that given to the infant appellant knocks at the door of the respondents' hospital, what is he entitled to expect?

[51] Lord Greene MR was of the view that a hospital's duty included the treatment of patients with reasonable care, and such duty is not discharged by delegation, whether or not any special skill was involved.

[52] Following in the same stead is Lord Denning who in *Cassidy v. Ministry Of Health* [1951] 2 KB 343, departed from the majority in the Court of Appeal who found the hospital liable in a medical negligence suit based on the principle of vicarious liability, and chose to find liability on the principle of non-delegable duty of care:

> I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for service.

[53] I can only hazard a guess that Lord Denning had himself learnt the full purport of the principle after *Gold v. Essex* (*supra*) as he was counsel in that case. In *Cassidy*, His Lordship chided himself for not having drawn this principle of non-delegable duty to the attention of the court there. According to Lord Denning, Lord Greene gave "no countenance to this error. He made the liability depend on what was the obligation which rested on the hospital authorities. He showed that hospital authorities were under an obligation to use reasonable care in treatment, whence it follows, on the authorities I have just cited, that they cannot get rid of that obligation by delegating it to someone else, not even a doctor or surgeon under a contract for services". His Lordship made no distinction between persons engaged under a contract of service and a contract for services:

> … the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff; all he knew was that he was treated in the hospital by people whom the hospital authorities appointed; and the hospital authorities must be answerable for the way in which he was treated.

[54] In *Roe v. Minister Of Health* [1954] 2 QB 66, Lord Denning revisited this principle in a case concerning the liability of a hospital for alleged negligence of a part-time anaesthetist:

> … the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors, but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, wholetime or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself.

[55] All these statements were *obiter* made in the context of cases involving staff employed in public hospitals under a statutory duty to provide treatment for patients, as observed by the Federal Court in *Dr Kok*. However, the court noted that the hospitals were nevertheless held to be under a non-delegable duty to patients regardless of their status of employment or relationship with the hospital itself. This aspect becomes particularly relevant when Act 586 and the related regulations are examined.

(iii) Act 586 – The Statutory Framework

[56] I move next to the matter of statute, that the statutory regime was a relevant consideration in *Woodland* and other cases. In *Woodland*, this may be gathered from Lord Sumption's concerns on imposing too burdensome a financial duty given the authority under which public service of education operates – see para. [25]. This is even more apparent in Lady Hale's judgment, see para. [30].

[57] In fact, statutory framework almost always is a relevant and necessary consideration in determining the issue of non-delegable duty of care – see *Roe v. Ministry Of Health* (*supra*) per Somerville LJ at p. 135 cautioning position of surgeons and others under the National Health Services Act may differ from voluntary or municipal hospitals. See also *Armes v. Nottinghamshire County Council* (*supra*), where Lord Reed reminded that while non-delegable duty of care may be deemed to have been assumed voluntarily, "it is of course possible for the necessary relationship to be created by statute … But everything turns on the particular statute. The point is illustrated by the decision of the Court of Appeal in *Myton v. Wood* (1980) 79 LGR 28, where a claim was made against a local education authority for the negligence of a taxi firm employed by the authority to drive children to and from school. The authority had no statutory duty to transport children, but only to arrange and pay for it. The claim was therefore dismissed". The legislations under scrutiny in *Armes* were the Children and Young Persons Act 1969, the Child Care Act 1980 and the Boarding-Out of Children Regulations 1955, SI 1955/1377.

[58] This exercise of examination of the relevant legislation is also reflected in *Hughes v. Rattan* [2023] 1 All ER 300 where the court examined the relevant agreements and contracts of the several dentists who had attended to the patient against the National Health Service (General Dental Services Contracts) Regulations 2005, SI 2005/3361, as amended before concluding on the five *Woodland* features. In *Gulf View Medical Centre Ltd v. Tesheira (The Executrix Of The Estate Of Russell Tesheira) (Trinidad And Tobago) & Another Appeal* [2022] UKPC 38, the Privy Council opined that a non-delegable duty can arise under statute, citing *Armes*. However, the issue was not further elaborated as the allegation of non-delegable duty was admitted on the pleadings. Both cases are post-*Dr Kok,* but a closer look at *Hughes v. Rattan* shows that the law has really remained unchanged under *Woodland,* save for the caution expressed by Lady Hale was repeated in slightly different terms by Lord Reed in *Armes*.

[59] While the boundaries are not clear-cut and will have to be examined on a case-by-case basis, the five *Woodland* features in the context of our legislative regime is the right place to start the determination of the existence and imposition of this non-delegable duty of care. Rightly so as legislative schemes determine a myriad of issues including the scope of application, interpretation and most of all, the intent of the legislation.

[60] So, what is the legislative regime in this country? For this, I once again turned head to both *Dr Kok* and *Dr Hari Krishnan,* where this was addressed. In *Dr Kok*, this court examined the Private Healthcare Facilities and Services Act 1998 (Act 586) and the related Regulations – see paras. [56] to [61] before concluding at para. [61] as follows:

> [61] Read in its entirety, we do not consider that the relevant legislation warrants the interpretation that private hospitals are mere providers of facilities and not medical treatment. On the contrary, the *legislative scheme clearly envisages that the function of private hospitals includes generally the 'treatment and care of persons who require medical treatment or suffer from any disease', and considers the services of medical practitioners as part of that function.* The notion that the duty of a hospital is confined only to its facilities and staff selection has long been rejected in the common law. Such a notion is also incongruent with societal expectations of private hospitals as healthcare service providers; most patients do not perceive hospitals as providers of all the utilities and backup services except medical treatment. Adopting Lord Greene's formulation, it is precisely medical treatment that patients expect when they knock on the door of the hospital.
>
> (emphasis added)

[61] In *Dr Kok*, ss. 2 and 78 of Act 586 were examined in detail before the court rejected the hospital's submission that it owed only a duty to take care of the facilities and not the treatment of Mr Soo. However, on the facts, this court found the second feature of *Woodland* was not fulfilled, that there was no antecedent relationship between Mr Soo and the hospital because Mr Soo

saw Dr Kok at his clinic outside of the hospital, both before and after the surgery and that the hospital merely provided the facilities. That being so, there was no assumption of responsibility for the treatment to pin any non-delegable liability on the hospital.

[62] It is only appropriate that the whole legislative scheme be examined but first, it must be made clear that it is not the intention of this court to say that the intent of the legislative scheme is any different from that already expressed in *Dr Kok*. It must be reiterated and emphasised that the legislative scheme clearly envisages that the function of private hospitals includes generally the 'treatment and care of persons who require medical treatment or suffer from any disease', and considers the services of medical practitioners as part of that function. This is consistent with the intent of Act 586, which in turn reflects and incorporate policy, that it is an Act to provide for the regulation and control of private healthcare facilities and services and other related health-related facilities and services and for matters related thereto. Interpreting legislation according to its purposive intent as provided by s. 17A of the Interpretation Acts 1948 and 1967 (Act 388) has been consistently applied by this court in a long line of cases. See for instance *Tan Kah Fatt & Anor v. Tan Ying* [2023] 2 CLJ 169; [2023] 2 MLJ 583; [2023] 2 MLRA 525; *Bursa Malaysia Securities Bhd v. Mohd Afrizan Husain* [2022] 4 CLJ 657; [2022] 3 MLJ 450; [2022] 4 MLRA 547; *AJS v. JMH & Another Appeal* [2022] 1 CLJ 331; [2022] 1 MLJ 778; [2022] 1 MLRA 214.

[63] The Act regulates and controls all private healthcare facilities and services. That regulation and control is through a system of registration and licensing of all private healthcare facilities and services – see ss. 3 and 4; regardless of whether the provision of healthcare facilities or services is by a sole proprietor, partnership or body corporate – see s. 6. Contravention of these provisions amount to an offence – see s. 5.

[64] The Act has 19 Parts; Part I – Part XIX:

Part I:	Preliminary
Part II:	Control of Private Healthcare Facilities and Services
Part III:	Approval to Establish or Maintain Private Healthcare Facilities or Services Other Than a Private Medical Clinic or a Private Dental Clinic
Part IV:	Licence to Operate or Provide Private Healthcare Facility or Services Other Than Private Medical Clinic or Private Dental Clinic
Part V:	Registration of a Private Medical Clinic and a Private Dental Clinic
Part VI:	Responsibilities of a Licensee, Holder of Certificate of Registration and Person in Charge

Part VII:	General Provisions Relating to Approval Licence and Registration
Part VIII:	Suspension and Revocation of Approval and License, Refusal to Renew the License, and Suspension, and Revocation of Registration
Part IX:	Closure of Private Healthcare Facilities or Services
Part X:	Blood Bank
Part XI:	Blood Transfusion Services
Part XII:	Mortality Assessment
Part XIII:	Quality of Healthcare Facilities and Services
Part XIV:	Board of Management and Advisory Committee
Part XV:	Managed Care Organization
Part XVI:	Enforcement
Part XVII:	Power of Minister
Part XVIII:	Miscellaneous
Part XIX:	Saving and Transitional Provisions

[65] As can be seen, the Act is fairly comprehensive and extensive in its ambit and scope, covering matters such as registration and setting up of healthcare facilities or services to the multitude of detailed matters that must be put in place, be it of facilities or personnel, in both quantitative and qualitative terms.

[66] From the definitions in s. 2 of various terms such as "healthcare facility", "healthcare services", "healthcare professional", "private healthcare services", "private healthcare facility"; "private hospital", just to name a few, it is also clear that the Act has very extensive application:

> "healthcare facility" means any premises in which one or more member of the public receives healthcare services;
>
> "healthcare services" includes:
>
> (a) medical, dental, nursing, midwifery, allied health, pharmacy and ambulance services and any other services provided by a healthcare professional;
>
> (b) accommodation for the purpose of any service provided under this Act;
>
> (c) any service for the screening, diagnosis, or treatment of persons suffering from, or believed to be suffering from any disease, injury or disability of mind of body;
>
> (d) any service for prevention or promotive of health purposes;

(e) any service for curing or alleviating any abnormal condition of the human body by the application of any apparatus, equipment, instrument or device or any other medical technology; or

(f) any health-related services.

"healthcare professional" includes a medical practitioner, dental practitioner, pharmacist, clinical psychologist, nurse, midwife, medical assistant, physiotherapist, occupational therapist and other allied healthcare professional and any other person involved in the giving of medical, health, dental, pharmaceutical or any other healthcare services under the jurisdiction of the Ministry of Health;

"private healthcare facility" means any premises, other than a Government healthcare facility, used or intended to be used for the provision of healthcare services or health-related services, such as a private hospital, hospice, ambulatory care centre, nursing home, maternity home, psychiatric hospital, psychiatric nursing home, community mental health centre, haemodialysis centre, medical clinic, dental clinic and such other healthcare or health-related premises as the Minister may from time to time, by notification in the *Gazette*, specify;

"private healthcare services" means any services provided by a private healthcare facility;

"private hospital" means any premises, other than a Government hospital or institution, used or intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease or who require dental treatment that requires hospitalisation;

[67] Put simply, Act 586 applies to all healthcare facilities and services which are not provided by the Government through public hospitals or institutions. In *Vincent Manickam David (Suing By Himself & As Administrator Of The Estate Of Catherine Jeya Sellamah, Deceased) & Ors v. Dr S Hari Rajah & Anor* [2017] 8 CLJ 27, the Court of Appeal described private hospitals in the following terms:

> [73] It is undeniable that in law, the second respondent is not a mere building or an ordinary company incorporated under the Companies Act 1965; or even a landlord; it is a healthcare facility where healthcare services regulated by and under the law, are provided to members of the public and to persons such as Catherine and the appellants. Any business arrangements that it structures to operate or best earn profits or even enable it to be a successful corporate sole, are of no relevance when it comes to the question of accountability and liability in law for the business of healthcare services. *That core business that the second respondent proffers can only be rendered through healthcare professionals such as the first respondent, the medical officer and the nurses in the instant appeal. Under such circumstances, the second respondent owes a duty of care to the clients or patients with whom the second respondent accepts and agrees to provide healthcare.* (emphasis added)

[68] Similar views were expressed by the Court of Appeal in *Dr Hari Krishnan*: A

> [58] In our view, Hospital is an institution that provides medical service and treatment to sick patients. Such services can only be given by doctors, nurses and other support staffs. A hospital cannot exist without doctors. The learned JC was correct to say that whatever arrangement entered between the doctors and the hospital, is purely internal. The negligence of the doctors cannot absolve the liability of the hospital by mere internal arrangement. When a person presents himself at the hospital for treatment he is seeking treatment from that hospital, knowing that the service would be provided through a doctor or someone at the hospital. A hospital on the other hand is nothing but a provider of medical care and services and would never exist independently without the service provider such as the doctors and nurses. **The relationship between doctors and the hospital is inextricable.** (emphasis added)

B C

[69] See also the *Chai Beng Hock v. Sabah Medical Centre Sdn Bhd & Ors* [2011] CLJU 33; [2011] 1 LNS 33; [2011] MLJU 1548; [2011] 2 AMR 742 as discussed at paras. [65] to [70] in *Vincent Manickam* (*supra*). D

[70] All these reasonings accord with the observations of the Federal Court in *Dr Kok* on how Act 586 is to be read and is echoed again in this judgment; that a reading of the Act in its entirety yields an understanding of the inter-relational obligations and functions between the hospital and those who actually render treatment and care to the patients; that hospitals are and remain, providers of both the facilities for the treatment and care of patients as well as the treatment and care rendered. E

[71] Several other provisions in Act 586 also point to this reading; ss. 31 and 35. Section 31 provides for the responsibilities of the licensee or holder of a certificate of registration of a private healthcare facility or service. Amongst the responsibilities, the licensee or holder must ensure that persons employed or engaged by the licensed or registered private healthcare facility or service are registered under any law regulating their registration, or in the absence of any such law, hold such qualification and experience as are recognised by the Director General. This is amplified in reg. 13 of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 (the Regulations). The statutory regime already recognises that a private hospital may employ or engage other persons in its premises, healthcare facility or service. Regardless of the engagement or employment, these persons must be properly registered or qualified. F G H

[72] Section 35 goes on to provide for the availability of a policy statement with respect to the obligations of the licensee or holder of the certificate of registration to patients using the facilities or services. This policy statement I

shall be made available on admission or registration and must cover such matters as may be prescribed. In fact, the policy statement has to be exhibited in a conspicuous part of the private healthcare facility or service. Again, these matters are further amplified in regs. 21 to 27 of the Regulations.

[73] Part XIII concerning "Quality of Healthcare Facilities and Services" further provide in s. 74 that every private healthcare facility or service shall have programmes and activities to ensure the quality and appropriateness of healthcare facilities and services provided. The information on such programmes and activities shall be furnished to the Director General as and when required by him. In fact, s. 75 empowers the Director General to give the licensee or the holder of a certificate of registration in respect of such facility or service "such directions in writing as he thinks necessary for the observance of the requirement or standard and shall state in the directions the period within which the holder of the approval, licensee or the holder of the certificate of registration is required to comply with the directions" where the Director General is of the opinion that any prescribed requirement or any prescribed standard which applies to the private healthcare facilities or service has not being observed. Section 108 further prohibits a private healthcare facility or service from publishing in any advertisement in such a manner as to mislead the public on the type or nature of the healthcare facilities or services or health-related facilities or services provided; or which is contrary to any direction on advertisement issued by the Director General. Act 586 unusually contains many instances where directions may be given by the Director General (such as the instant provision) or the prescribing of duties, responsibilities or even policy statement – see ss. 31(1)(d) and 35(2).

[74] Next, s. 38 and Part XVII of the Regulations further provides for "Special Requirements for emergency care services". This is of particular relevance in this appeal.

[75] Section 38(1) provides that every licensed and registered private healthcare facility or service shall at all times be capable of instituting, and making available, essential life-saving measures and implementing emergency procedures on any person requiring such treatment or services. In reg. 230, a private healthcare facility or service shall have a well-defined care system for providing basic outpatient emergency care services to any occasional emergency patient who comes or is brought to the private healthcare facilities or services by chance. Regulation 230(3) further requires immediate emergency care services which include life-saving procedures when life, organ or limb is in jeopardy and management of emergency psychiatric conditions must be provided. The assessment of a patient's condition to determine the nature, urgency and severity of the patient's immediate medical need and the timing and place of the patient's care and treatment in the private healthcare facility shall be done by amongst others, a registered medical assistant. Regulations 230(8) and (9) anticipate the

patient being transferred elsewhere for treatment and care; that pending such transfer, the patient shall be rendered resuscitative and life-support procedures.

[76] However, where the emergency care services are provided on a regular basis, as was the case in the respondent, reg. 231 applies. In such a situation, reg. 231(12) requires "additional healthcare professional and other ancillary staff if the circumstances demands" shall be made.

[77] All these provisions fortify the understanding that the hospital is and remains responsible for not just the efficacy of premises or facilities but also for the treatment and care of the patients; regardless of how and who the responsibility may have been delegated to. This is the intent of the legislative scheme, to the extent that the policy of the private hospital or healthcare facility or service is required to be placed in a conspicuous place of the premises so that persons coming to the hospital or healthcare facility or service are aware of such policy. Implicit in this structure and legislative scheme is already the balance and incorporation of the elements of fairness, just and reasonableness which need not be reconsidered as an entirely separate exercise or consideration. Persons approaching, using and relying on the treatment and healthcare rendered in these facilities and services should never have to concern themselves with the issues of responsibility and separate accountability as negligence and mishaps would be furthest from their minds.

[78] On the facts in this appeal, the respondent is no doubt a private healthcare facility as it is a private hospital used and intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease. The respondent had also made the following statement to the appellant and to all persons using its healthcare facilities and services, available on its website, concerning, amongst others, its facilities, treatment, care and procedures:

> Patients benefit from advanced medical diagnostics, treatment and the personal care that only comes in facilities where the focus is on each patient. Our facilities are comprehensive so you can rest assured that we have all that you need for your treatments and procedures. State-of-the-art equipment ensures that we are up to date with medical technology and updates. To find out what we have to offer, please the list below:
>
> As a patient of Columbia Asia Hospital, you can expect:
>
> (i) To be informed of your medical treatment and care
>
> (ii) To be treated with courtesy and respect
>
> (iii) To be provided with adequate information and informed consent
>
> (iv) To be provided with a channel to address your feedback
>
> (v) To be informed of the estimated charges

(vi) To see an itemised bill upon request

(vii) To know the identity and professional status of your care provider

(viii) To be ensured the privacy and confidentiality of your medical record

(ix) To receive care in an environment conducive to good health

[79] From the reading of all these provisions, it is clear as daylight that the legislative scheme intends private hospitals such as the respondent to remain responsible for the treatment and care of the patients regardless of to whom they may have employed, engaged or delegated that task or responsibility. This remains so even if the hospital is rendering emergency care services. In the case of the respondent, it renders such services on a routine basis.

[80] As for the five *Woodland* features, I have no hesitation in finding them met. The first condition is easily fulfilled in the case of medical negligence such as the present appeal. The appellant is indeed in a vulnerable position and is totally reliant on the respondent for his care and treatment; more so when the appellant was admitted to its emergency services. As for the second feature of an antecedent relationship, this is well met by both statutory frameworks which puts into place a relationship which deems an assumption of a non-delegable duty of care; and also from the factual circumstances. I have already dealt with the statutory relationship.

[81] On the facts, the appellant was admitted to and in the respondent's emergency facilities and treated by its medical officer, prior to being referred to the first and second defendants. The reference to these defendants was by the respondent's own medical officer. These defendants are also part and parcel of the necessary professionals who must be available if the respondent was to provide emergency services on a routine basis – see reg. 231. More importantly, the negligent act complained of took place during the care and treatment rendered within the respondent's premises using its facilities and services. It did not happen anywhere else; and this appears to have been overlooked in the case of *Dr Kok*. While Mr Soo may have been seen by Dr Kok both before and after the operation at his clinic outside Sunway Medical Centre, the operation where the medical negligence and cause of action took place was well within the walls of the hospital.

[82] In any case, given the extensive provisions in Act 586 and the Regulations made thereunder, it cannot be ignored that the intent of the legislation is that the respondent assumes a non-delegable duty of care to the appellant and it remains liable personally for the negligence of the second defendant. It makes no difference the presence of the other defendants, save that the tort of negligence must always first be proved on the facts.

[83] In this appeal, that is not an issue. The elaborate, extensive and detailed provisions in both the parent Act and the Regulations are enacted for the purpose of ensuring patient, safety and care whilst being treated in our

private hospitals, private healthcare facilities and services, always remains paramount and to be observed by the private hospital or private healthcare facility or service itself. Not only does common law no longer see hospitals as mere providers of premises, utilities, facilities or backup services for such treatment and care of the patient, the law provides that private hospitals are themselves providers of such care and treatment of the patient in which case, the private hospitals or healthcare facilities or services owe a non-delegable and personal duty of care to persons who knock on their door and seek treatment and care.

[84] As for the third and fourth features, it is clearly evident that the appellant had no control over how the respondent was to perform its function of rendering emergency care and treatment; whether it would be rendered personally or through employees or some third parties such as the professionals it had engaged and to whom it had delegated the integral function of treatment and care of patients at its emergency services. In fact, having assumed a positive duty of care to the appellant in respect of emergency services, the respondent had delegated to its medical officer, and to the first and second defendants, the performance of its obligations and these persons were indeed performing those delegated functions at the material time.

[85] As for the fifth feature, it is undeniable that the second defendant was negligent in the performance of the very function of rendering proper emergency care and treatment of the appellant that was assumed by the respondent but delegated to her by the respondent.

[86] With all five features satisfied, it is clear that the respondent has assumed a non-delegable duty of care that it owes personally to the appellant, a patient that is admitted to its emergency services. The defence of independent contractor thus is not sustainable in law and on the facts and ought to have been rejected by the courts below.

Loss Of Earnings

[87] The appellant was awarded compensation for loss of earnings based as follows:

(i) special damages totalling RM265,200 calculated on a multiplicand of RM2,600 per month x multiplier of 90 months;

(ii) pre-trial damages totalling RM88,380 calculated on a multiplicand of RM2,946 per month x multiplier of 30 months.

[88] At the time of the incident, the appellant was 35 years of age. According to s. 28A(2)(d)(ii) of the Civil Law Act 1956 (Act 67), the multiplier for his loss of earnings would be ten. There is no issue in this regard.

[89] However, in respect of the multiplicand, the High Court fixed it at RM2,600 per month. This figure is said to disregard the appellant's earnings derived from allowances, fees and monthly salaries received as a director of two family-owned companies for which tax had been paid. The multiplicand only recognised his basic salary. It will also be noticed that different multiplicand was used, depending on whether it was pre-trial loss or special damages.

[90] In this regard, the respondent had argued that this aspect is not appealable given that it is the sole respondent in this appeal. There is no appeal against the second defendant, the principal tortfeasor.

[91] Dealing first with the matter of whether the appeal in respect of quantum is still available to the appellant. With respect, the respondent's argument is not tenable. The appeal against the respondent is in respect of both liability and quantum. This is clear from the notice of appeal filed. This is sufficient for this court to deal with the whole issue of quantum. I must add that there is no suggestion that there is accord and satisfaction, whether in fact or in law, to deprive the appellant of this appeal. The respondent's submission here is thus without merit.

[92] Having examined the law and the facts, I agree with the appellant's submissions that the courts below fell into error in disregarding these earnings when computing the multiplicand, and in recognising different multiplicand. These earnings, for which tax has been paid, are clearly within the meaning of "earnings by his own labour or other gainful activity" under s. 28A of the Civil Law Act 1956 (Act 67) and should thus be recognised. As for the multiplicand, that should be constant. I therefore agree with the submissions made by learned counsel for the appellant on the correct award, that it should be a constant sum of RM8,750 per month with the multipliers as suggested by the appellant.

[93] As for the element of interest, there is no reason to disturb the exercise of discretion of awarding interest at the rate of 4% per annum for the relevant periods.

[94] Finally, a note on indemnity. The respondent has invited this court to order that the second defendant indemnify the respondent in the event that it is found liable. I do not find this to be right or available in law.

[95] First, the second defendant is not a party to this appeal. More importantly, it flies in the face of the earlier findings that the respondent owes a non-delegable duty of care and it remains liable regardless to whom it may have employed or engaged to carry out that duty of care. The principle imposes a personal liability on the respondent, over and above that against the tortfeasor.

[96] With the deliberations as set out above, I do not see the need to specifically answer the questions as posed. The *Woodland* features have to be refined in the context of our Act 586 in the manner discussed above.

Conclusion

[97] For the above reasons, the appeal is allowed. Judgment is entered against the respondent for the full sum as submitted by the appellant, subject to the considerations earlier mentioned.

Zabariah Mohd Yusof FCJ (dissenting):

Introduction:

[98] The appeal herein concerns the imposition of a non-delegable duty of care on a private hospital for the alleged negligence act of its independent contractor, a medical practitioner.

[99] In this judgment, parties shall be referred to, as in the High Court.

[100] In the High Court, the plaintiff filed a medical negligence claim against the first defendant (D1), second defendant (D2), who at the material time, practiced as registered medical practitioners at the third defendant (D3), an established medical centre. D1 and D2 are independent contractors in D3, by virtue of the residential consultant agreement.

[101] After a full trial, the High Court dismissed the claim by the plaintiff against D1 and D3 and found liability only against D2 and award damages of RM1,967,772.70 to the plaintiff. The Court of Appeal affirmed the findings and decision of the High Court on liability but varied the quantum of damages to be awarded against D2 to the sum of RM2,111,872.70.

[102] The appeal herein is only against the decision of the Court of Appeal, which affirmed the decision of the High Court in dismissing the claim of the plaintiff against D3. There is no appeal by D2 or by the plaintiff against the finding of liability and award of damages against D2. It is to be noted that the amount of damages awarded against D2 was over and above D2's medical indemnity for malpractice.

Questions Of Law

[103] The plaintiff has been granted leave to appeal to this court on the following questions of law:

(i) whether the owner and manager of a hospital is in law a provider of healthcare and owes a non-delegable duty of care to patients as stated by the English Court of Appeal in the post-*Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal* [2017] 10 CLJ 529; [2018] 1 MLJ 685 case of *Hughes v. Rattan* [2022] EQCA Civ 107.

(ii) whether the judgment of the Federal Court in *Dr Kok Choong Seng* regarding the tort of negligence in a private hospital applies where the owner and manager of the hospital owes separately duties of care in contract and by statute?

(iii) whether the owner and manager of a private hospital would be liable to patients under a non-delegable duty of care when a doctor practising in the hospital as an independent contractor has insufficient professional indemnity for malpractice?

(iv) if the answer is "yes", whether the owner and manager, as a provider of healthcare, may escape liability for a breach of such duty of care committed by a doctor because the doctor is an independent contractor who has been engaged to practise in the hospital?

(v) whether there is a statutory duty of care, independent of a duty in negligence or contract, owed by the owner and manager of a private hospital under the Private Healthcare Facilities and Services Act 1998 and the subsidiary legislation made thereunder?

(vi) whether the fees received by a director of a company from the company are "earnings by his own labour or other gainful activity" under s. 28A(2)(c)(i) of the Civil Law Act 1956?

(vii) in light of the post-*Dr Kok Choong Seng* case of *Armes v. Nottinghamshire County Council* [2018] 1 All ER 1 decided by the Supreme Court of the United Kingdom, whether after applying the five-feature test in *Woodland*, a court must additionally apply the test of whether it is fair, just and reasonable to impose a non-delegable duty of care in the circumstances of the case?

[104] The questions of law can be categorised into the following issues:

(i) whether D3 owes a non-delegable duty of care to the patient (questions (i), (iii), (iv) and (vii));

(ii) whether D3 had breached some statutory duty imposed by the law (question (v)); and

(iii) whether D3 owes a duty of care in tort where D3 owes separate duties of care in contract and by statute (question (vi)).

[105] None of the questions framed, relate to issues of breach of contract or in respect of terms which may be implied.

The Issue In The Appeal

[106] The appeal revolves on the question of whether a private hospital (in this case D3) can be made liable for a tort committed by an independent contractor (D2) appointed by it (D3), premised upon the principle of non-delegable duty of care.

Brief Facts

[107] The plaintiff brought the present claim for and on behalf of her husband, who was 43 years (hereinafter referred to as "the patient") at the time of filing this action.

[108] On 10 March 2010, the patient had undergone certain medical procedures known as tonsillectomy, palatal stiffening and endoscopic sinus surgery (operation) at the Subang Jaya Medical Centre ("SJMC"). On 22 March 2010, at 3am while at home, the patient suffered bleeding at the site of the operation. The plaintiff contacted the patient's doctor in SJMC, Dr Puraviappan, who told her to bring the patient to SJMC immediately, however, the plaintiff decided to seek treatment at D3 as it was nearer to home and the bleeding was heavy (para. 22 of the statement of claim).

[109] The patient was brought to the Accident and Emergency Department of D3. The patient was attended by a medical officer (Dr Ng) of D3, who was on duty at the Accident and Emergency Department, who subsequently called Dr Megat Shiraz (D1), informing D1 that there was a patient having secondary haemorrhage from a tonsillectomy performed earlier at SJMC on 10 March 2010. In the meantime, D1 ordered Dr Ng to give ice cubes to the patient for gargling with a view to stop the bleeding.

[110] Upon arrival at the hospital (D3), D1 examined the patient and advised the patient to undergo surgery to stop the bleeding. The patient agreed and signed the consent form and he was transferred to the operating theatre (OT) accompanied by D1 and D2. While at the OT airlock area, the patient suffered more profuse bleeding despite earlier attempts at treating the complications (para. 23 of the statement of claim). D1 and D2 immediately pushed the patient into the OT and attempted to stop the bleeding as well as secure his airway. The bleeding caused difficulty in administering the patient with anaesthesia in order to intubate. The first attempt to intubate was unsuccessful due to continuous vomiting and bleeding. D1 used his index finger to press on the left tonsillar bed and immediately the bleeding stopped. D2 was then successful in intubating the patient and securing his airway.

[111] D1 proceeded to perform surgery. However, the patient's condition became critical where the patient's blood pressure and the readings of his blood oxygen level dropped. The patient was commenced on cardiopulmonary resuscitation (CPR) while in the OT. Following the CPR, the patient's vital signs recovered, and the patient was then admitted into the Intensive Care Unit of D3 for continued post-surgical care and management. Post-surgery, the patient suffered hypoxic brain damage.

[112] On 28 March 2010, on the instructions of the family, the patient was transferred to SJMC for further management.

[113] It was alleged that D1 and D2 failed to undertake the appropriate anaesthetic management adequately when treating the patient's complications before proceeding with the surgery which resulted in the patient suffering severe hypoxic brain damage with permanent mental and physical disabilities.

[114] It was contended by the plaintiff that:

(i) D3 is vicariously liable for the negligence of D1 and D2 (para. 29 of the statement of claim);

(ii) the defendants' negligence and/or statutory duties are as regard, but not limited to, the diagnosis, history taking, advice giving, treatment and systems failure of D3 which caused or materially contributed to the injuries and loss (paras. 26 to 38 of the statement of claim); and

(iii) D3 owed a non-delegable duty of care to the patient (para. 29 of the statement of claim).

Findings By The High Court

[115] On 30 July 2020, the High Court allowed the plaintiff's claim against D2 only and damages is to be paid by D2 to the plaintiff. The plaintiff's claim against D1 and D3 were dismissed.

[116] As the appeal herein is only against D3, I do not find it necessary to belabour on the findings of liability by the High Court against D1 and D2, in this judgment.

[117] The material findings by the High Court which was affirmed by the Court of Appeal against D3 are as follows:

(i) in determining the liability of D3, the learned trial judge scrutinised the averments, facts, and allegations of negligence raised in the pleadings (para. 4 of the judgment). Premised on the pleadings, submissions and the expert opinion of the plaintiff, the learned trial judge held that the cause of the hypoxic brain damage to the patient was due to the inappropriate or delayed timing of the induction of anaesthesia which was wholly undertaken by, and as a result of the clinical decision of D2;

(ii) the plaintiff failed to plead specifically against D3 for causing the said delayed induction of the anaesthesia on the patient, as a result of which D2 was found liable to the plaintiff (paras. 72 and 73 of the judgment);

(iii) there was no evidence to the contrary that the patient had not been properly managed at D3 according to normal medical standards. No criticism was directed at the service and treatment provided by D3 to the patient or the facilities available at D3 for being inadequate (para. 74 of the judgment);

(iv) it is trite and settled law that the plaintiff in a medical negligence suit against a hospital must lead credible evidence to prove that any alleged shortcomings in the care, management and treatment rendered had caused/resulted in the adverse outcome suffered by the patient. In this case, the plaintiff failed to adduce any credible or sufficient evidence to prove the pleaded particulars of negligence against D3, which can be found at para. 26.38 of the statement of claim;

(v) with regards to the contention of vicarious liability and breach of non-delegable duty of care, both the consultants, D1 and D2, were carrying out their practice in the hospital at all material times, not as employees, servants or agents of the hospital but as independent contractors. Hence, D3 ought not to be held liable to the plaintiff for the negligence of D2, if any, unless negligence is satisfactorily proved against D3 as well. D2's contract with D3 is evidenced by the resident and consultant agreements produced in court which specifically state that D2 is an independent contractor, which is also admitted by the plaintiff in her pleadings. Hence, the plaintiff could not now contend that there was a private agreement or arrangement between D2 and D3 without the knowledge of the patient.

Analysis And Decision

[118] The plaintiff's pleaded causes of action against D3 are that:

(i) D3 owed the plaintiff a non-delegable duty of care;

(ii) D3 had breached its contractual/statutory and/or other duties; and/or

(iii) D3 is vicariously liable to the patient for D2's tort.

[119] As to the plaintiff's claim against D3 premised on vicarious liability, it has been brought to the attention of this court that, the issue of vicarious liability has been abandoned by the plaintiff in the Court of Appeal. Given the aforesaid, the issues to be addressed in this judgment are limited to the causes of action at para. (i) and (ii) above.

Non-delegable Duty Of Care

[120] Questions (i), (iii), (iv) and (vii) relate to the law on the doctrine of non-delegable duty of care. The doctrine of non-delegable duty of care imposes liability on the non-tort feasor *ie*, on the person who is not the one who committed the negligent act.

[121] One of the earliest pronouncements on the said doctrine in hospital cases was the minority judgment of Lord Greene in the English Court of Appeal case of *Gold v. Essex County Council* [1942] 2 KB 293, at 301. The majority of the Court of Appeal therein decided the case according to the principles of vicarious liability. In subsequent years, Lord Denning, in his minority judgment in the case of *Cassidy v. Ministry Of Health* [1951] 2 KB

343, identified the underlying principle of the doctrine of non-delegable duty of care "where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services." Again, the majority in *Cassidy v. Ministry Of Health* decided the case on the application of the principles of vicarious liability.

[122] These analysis of the factors that gave rise to the non-delegable duty of care as expounded by Lord Greene and Lord Denning in *Gold v. Essex County Council* and *Cassidy v. Ministry Of Health* respectively, were later given broad recognition by Lord Sumption in *Woodland v. Essex County Council* [2013] UKSC 66. Although Lord Sumption did not subscribe to every *dictum* in the Australian cases referred therein, nevertheless, he was of the view that they were correct in identifying the underlying principles and the analysis of the factors that gave rise to a non-delegable duty of care (as reflected at para. 23 in the judgment of *Woodland*).

[123] In the context of cases involving staff employed in hospitals which provide treatment to patients, the cases pre-*Woodland*, (namely *Hillyer v. The Governors Of St Bartholomew's Hospital* [1909] 2 KB 820; *Gold v. Essex County Council; Cassidy v. Ministry Of Health, Roe v. Minister Of Health* [1954] 2 QB 66; *X & Ors (Minors) v. Bedfordshire County Council; M (A Minor) & Anor v. Newham London Borough Council & Ors; E (Minor) v. Dorset County Council & Other Appeals* [1995] 3 All ER 353; [1995] 2 AC 633), which made statements on the doctrine/concept of non-delegable duty of care were merely *obiter*. These cases were dealt with, extensively by this court in *Dr Kok Choong Seng & Anor v. Soo Cheng Lin & Another Appeal* [2017] 10 CLJ 529; [2018] 1 MLJ 685 (see paras. 46 to 55).

[124] The numerous cases which dealt with, and imposed the doctrine of non-delegable duty of care were difficult to reconcile and rationalise, despite the various attempts by commentators and authors to explain the theoretical basis for the imposition of non-delegable duty of care. Previous cases have shown that non-delegable duties have arisen in numerous contexts, namely:

(i) liability for escapes of substances likely to do mischief *(Rylands v. Fletcher* [1866] LR 1 Exch 265);

(ii) liability for inherently hazardous activities (*Honeywill v. Larkin* [1934] 1 KB 191);

(iii) liability for dangers on public highway (*Holliday v. National Telephone Co* [1899] 2 QB 392);

(iv) liability of employer to its employee (*Wilson & Clyde Coal Co Ltd v. English* [1938] AC 57); and

(v) liability arising from statutory duties (*Smith v. Baird & Co Ltd* [1940] AC 242).

which make it impossible to identify a single conceptual basis capable of unifying all forms of such duty. In reality, previous cases have illustrated that, when the straightforward action in tort, be it negligence, nuisance or trespass, are not available to a plaintiff, the doctrine of non-delegable duty provides a useful tool to resolve the impasse, allowing the court using policy justifications to impose liability on a defendant, who is not the wrongdoer. It appears to be a device in the pursuit of social justice, to circumvent the limitations of the doctrine of vicarious liability, so as not to deprive innocent victims of remedy in cases of negligence, as very well illustrated in *Cassidy v. Minister Of Health*. There, the patient, suffered injury during a medical procedure performed by the staff of the hospital in question. Unfortunately, the exact cause of the injury and the particular employee of the hospital responsible for the negligence could neither be ascertained nor identified. The doctrine of *res ipsa loquitor* was applied, which allowed the court to infer negligence on the part of the hospital based on the nature of the injury, even without direct evidence of negligence. Such were the surrounding circumstances where the injury could not have occurred without some degree of negligence on the part of the hospital or its staff. It is in that context that the hospital was presumed to be liable.

[125] Similarly in *Woodland*, where the doctrine of vicarious liability was not applicable, and the pleadings were less than satisfactory, the doctrine provide the resolution to such deficiency. The court provided a rationalisation for the imposition of the non-delegable duty of care, generally, creating two broad categories of claims based on positive assumption of responsibility towards the victim in question, namely:

(i) where the defendant employs an independent contractor to perform an inherently hazardous or extraordinarily hazardous or liable to become so in the course of his work. In such situation, the duty of care cannot be delegated to the independent contractor and the principal will remain liable throughout; or

(ii) where there exist special relationships between the principal and the victim such that the principal is not permitted to delegate his tortious liability to an independent contractor.

[126] Our present appeal falls within the second category.

[127] The second category requires an assessment of the relationship between the parties, and that relationship created a duty of care between the plaintiff and the defendant which could not be delegated to independent third parties.

[128] In this regard, Lord Sumption in *Woodland* had formulated five identifying features, in cases in the second category, where non-delegable duty of care applies:

(i) the claimant is a patient or a child, or for some other reason, is especially vulnerable or dependent on the protection of the defendant against the risk of injury.

(ii) there is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself:

(a) which places the claimant in the actual custody, charge or care of the defendant, and

(b) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm and not just a duty to refrain from conduct will foreseeably damage the claimant. It is characteristic of such relationships that involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of school children.

(iii) the claimant has no control over how the defendant chooses to perform those obligations, *ie*, whether personally or through employees or through third parties.

(iv) the defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.

(v) the third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

[129] Lord Sumption cautioned against imposing unreasonable financial burdens on those providing critical public services and the features were intended to identify circumstances in which the imposition of a non-delegable duty should be imputed to schools (with which *Woodland* was concerned) only in so far as it would be fair, just and reasonable to do so. Lord Sumption was of the view that, based on the criteria, there would not be any unreasonable burden imposed on the school by recognising the existence of a non-delegable duty. Baroness Hale agreed that the principle of personal liability for the breach of non-delegable duty will apply in circumstances as set out by Lord Sumption subject to the usual provisos that such judicial statement is not to be treated "as if they were statutes and can never be set in stone" (para. 38 of *Woodland*).

[130] Lord Sumption indicated that non-delegable duty of care is distinct from the doctrine of vicarious liability, which according to orthodox theory, imposes secondary liability.

[131] This court in *Dr Kok Choong Seng* has accepted and adopted the guiding principles as refined in *Woodland* as a useful starting point in establishing the imposition of a non-delegable duty of care (refer to para. [62] of the said case). This court emphasised that as the imposition of this duty is an onerous obligation and non-fault-based, the proviso in *Woodland* has to be kept in mind, namely, that such duties should only be imposed where it is fair, just and reasonable to do so, based on the facts and circumstances of the case, developed incrementally from existing categories and consistent with underlying principle:

> [62] ... We, therefore, reject the arguments by counsel that all private hospitals are always or never under a non-delegable duty to patients, in respect of the medical treatment provided by doctors practising there. *Given that the role of the hospital may vary from patient to patient, the extent and scope of the hospital's duty towards the patient must be ascertained from the facts and circumstances of the case.*
>
> ...
>
> [70] ... *given the fact-sensitive nature of the Woodland test, whether private hospitals are in breach of a non-delegable duty to their patients by reason of the negligence of doctors practising there cannot be predetermined by a general pronouncement, but assessed based on the facts and circumstances of each case.* (emphasis added)

[132] From the aforesaid, this court in *Dr Kok Choong Seng* did not make any general determination that the doctrine applied to all private hospitals *vis-à-vis* doctors who practice there as an independent contractor.

[133] Counsel for the plaintiff has conflated the concepts of non-delegable duty of care with that of vicarious liability, which is contrary to what has been indicated by Lord Sumption and by this court in *Dr Kok Choong Seng*, which held that this is a misconception as both are distinct in nature and basis:

> [38] *Non-delegable duties have been erroneously considered as a "kind of vicarious liability", and adopted as part of the test to determine vicarious liability in some cases. This is a misconception.* The two doctrines are similar in effect, in that they result in liability being imposed on a party (the defendant) for the injury caused to a victim (the plaintiff) as a result of the negligence of another party (the tortfeasor). *However, it bears emphasis that non-delegable duties and vicarious liability are distinct in nature and basis.* (emphasis added)

[134] The similarity is that, both vicarious liability and non-delegable duty of care result in liability being imposed on a party (the defendant) for injury caused to a victim (the plaintiff) as a result of negligence of another party.

[135] In vicarious liability it imposes liability on the defendant for the tortfeasor's breach of duty towards the plaintiff, based on relationship of employment between the defendant and the tortfeasor.

[136] Non-delegable duty of care arises because:

(i) of an antecedent relationship between the defendant and the claimant;

(ii) the duty is a positive or affirmative duty to protect a particular class of persons against a particular class of risks, and not simply a duty to refrain from acting in a way that foreseeably causes injury;

(iii) the duty is by virtue of that relationship personal to the defendant. The work/duty required to be performed may be delegable. But the duty itself remains to the defendant. Its delegation makes no difference to his legal responsibility for the proper performance of a duty which is in law his own.

[137] Theoretically, *Woodland* did not in any way, vary nor extend the doctrine of vicarious liability, because the appeal therein has got nothing to do with vicarious liability (para. 4 of the judgment). Hence, the well-established principle that the torts of independent contractor does not give rise to vicarious liability, remains intact. Non-delegable duty remains as an exception to the no fault principle. In other words, for clear-cut cases of negligence of independent contractors where remedy/compensation is available, there is no need to impose liability on the non-tortfeasor premised on non-delegable duty of care. This is elaborated in paras. 165, 166 and 173 of this judgment.

[138] To rely on *Woodland* in the determination of non-delegable duty of care, one must be wary of the context in which the case was decided (this is elaborated at paras. 168 and 169 in this judgment). The Supreme Court in *Woodland* adopted the approach of a specific policy justification for the imposition of the non-delegable duty of care, namely the non-contractual assumption of responsibility. This non-contractual assumption of responsibility exists in parallel to the duty owed by a contracting party to perform the contractual services with reasonable care and skill. When this very duty is breached, the claimant in a contractual relationship with the defendant will be able to bring a claim for breach of contract regardless of the status of the individual the defendant employed to do the work. This became important in the context of schools where education may be provided by private or public-funded schools.

[139] The other concern of the Supreme Court in *Woodland* is the trend of outsourcing of the key and integral services of the school to independent contractors leaving claimants with no remedy, as vicarious liability is not applicable in such situations. The imposition of the assumption of responsibility of non-delegable duty operates to fill this gap created by the outsourcing of those key services to independent contractor. The Supreme Court also sought to avoid being seen as being discriminatory between victims injured in private schools and one injured in public funded schools, as a non-delegable duty was the appropriate means of securing equal protection, and the school's responsibility was not discharged by choosing

competent people to do it. This was the factual matrix and context in which *Woodland* was decided premised on policy considerations. In other words, the doctrine of non-delegable duty of care provides the essential context to the decision, as the facts in *Woodland* fall outside the scope of the vicarious liability doctrine (para. 2 of the judgment). It is this precise reason (the negligent party was an independent contractor rather than an employee), that this case went all the way to the Supreme Court.

[140] In *Woodland* the degree of proximity between the parties creates the expectation of the justification for legal responsibility on the part of the education authority. In this regard, one of the features formulated by Lord Sumption which is the presence of antecedent relationship between the defendant and the victim, justifies the imposition of a non-delegable duty on the defendant. The High Court of Australia in *Kondis v. State Transport Authority* (1984) 154 CLR 672, provided some insight on this element. Although the case was argued on the basis of vicarious liability, Mason, Deane and Dawson JJ agreed that it was decided on the ground that the relevant duty was non-delegable. Mason J explained the basis in which the law holds some duties to be non-delegable:

> 32. ... when we look at the classes of case in which the existence of a non-delegable duty has been recognised, it appears that *there is some element in the relationship between the parties that makes it appropriate to impose on the defendant a duty to ensure that reasonable care and skill is taken for the safety of the persons to whom the duty is owed ...* (emphasis added)

[141] In *New South Wales v. Lepore* (2003) 212 CLR 511, Gummow and Hayne JJ suggested that in each case in which non-delegable duty of care had been held to exist, there was:

> *... a relationship in which the person owing the duty either has the care, supervision or control of the other person or has assumed a particular responsibility for the safety of that person or that person's property.* It is not suggested, however that all relationships which display these characteristics necessarily import a non-delegable duty. (emphasis added)

[142] "Antecedent relationship" which is a feature of the doctrine refers to a pre-existing relationship between the hospital and the patient which places the patient in the actual custody of the hospital. It is possible to impute the assumption of responsibility to the defendant by virtue of the special character of his relationship with the claimant. It is premised upon the assumption of a positive duty to protect a claimant/plaintiff from harm. It may be an express assumption of such duty. Where it is not, it must be capable to be inferred from the circumstances of the case, whereupon the assumption of such duty may be imputed. This is the pivotal legal nexus between the claimant and the defendant without which the law may not impose liability. This can be discerned from an analysis of the five features as set out by Lord Sumption which has been adopted by this court in *Dr Kok Choong Seng* (at para. 36 of the judgment).

[143] In the present appeal, the court is required to evaluate and determine the nature of the relationship between D3 and the patient and the connection between the relationship and the wrongful act of D2. This determination is a question of fact premised upon a consideration and evaluation of multiple factors and vary from case to case.

[144] Lord Sumption, in his wisdom, expected that this will open floodgates for new liability, hence, cautioned that tortious liabilities based not on personal fault but on duty to ensure that care is taken, should be an exception rather than the rule and circumscribed. A perusal of the judgment in *Woodland*, disclosed that the legal framework of non-delegable duty of care requires a high degree or extent of vulnerability. To that extent, imposing this duty on hospitals for all cases would be generalising that all patients are inherently vulnerable due to their dependence on the hospital for their care. Patients are capable of processing information and making decisions as to which hospitals are suitable to their needs, although the doctors in attendance would take into account of the patient's requirements and concerns. More often it is the choice of a particular doctor/specialist which determines where the patient seeks for treatment. This aspect has some relevance to the "vulnerability" issue in hospital cases, which differs from school pupils who are inherently vulnerable and immature of making their own decisions and rely very much on the school authorities (which requires a high standard of the duty of care) as compared to patients of hospitals. Hence, to apply the "vulnerable issue" as enunciated in *Woodland* to all hospital patients generally is not appropriate. Lord Sumption and Baroness Hale crafted the legal framework for non-delegable duty to be applicable with substantial control and restrictions as tort law emphasises the non-fault principle. *Woodland* has certainly not liberalised the ambit of non-delegable duty.

[145] With that factual matrix and the legal principle in determining the non-delegable duty of care, I proceed to address the questions of law posed.

Question (i)

[146] Firstly, I have to address on the usage of the term "owner" or "manager" as found in the first limb of question (i).

[147] Private hospitals, like D3 are regulated by the Private Healthcare Facilities and Services Act 1998 (PHFSA) and the statutory regulations thereunder, namely the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 (the Regulations).

[148] The terms "owner" or "manager" are not used in the PHFSA or the Regulations. Liabilities and responsibilities are imposed on "licensee". The PHFSA and Regulations do not expressly impose civil liability on the persons owning or directing, or otherwise controlling a licensee. Neither can it be inferred from the provisions.

[149] Hence, there is no statutory basis to generally hold an owner or manager liable for civil claims where they are not the licensee. Where the licensee is a company, this preclusion applies to its shareholders, directors and management. Therefore, the first limb to the question which queried "Whether the owner and manager of a hospital is in law a provider of healthcare and owes a non-delegable duty of care to patients" is a misnomer and it does not qualify as a question that can be applied generally.

[150] However, as far as the facts of our case is concerned, D3 conceded in the pleadings that it is the owner and manager of D3, but not clear whether D3 is the licensee.

[151] In the second limb of question (i), the plaintiff seeks to have this court revisit its decision in *Dr Kok* due to the decision of the English Court of Appeal in *Hughes v. Rattan* with the aim of definitively establishing that private hospitals are liable, by reason of a non-delegable duty of care to patients, irrespective of the circumstances of a given case, and to further impose liability on the owners and managers of a private hospital beyond what *Woodland* has expounded.

[152] In this regard, answering the question in the affirmative as suggested by the plaintiff, would firstly, run contrary to what has been held by *Woodland*, which has been adopted and accepted in *Dr Kok Choong Seng*. The latter case rejected "the arguments by counsel that all private hospitals are always or never under a non-delegable duty to patients, in respect of the medical treatment provided by doctors practising there" and subsequently held that the determination is highly fact-sensitive (refer to para. 62 of the judgment). Therefore, a general all-encompassing pronouncement as suggested by the appellant in question (i) is certainly out of the question.

[153] Secondly, *Dr Kok Choong Seng* is a recent decision on the application of the non-delegable duty of care and has been adopted and followed in numerous cases subsequent thereto by this court, which decisions were grounded on the principles of the doctrine stated therein, amongst which are:

(i) *Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor And Another Appeal* [2018] 3 CLJ 427; [2018] 3 MLJ 281; and

(ii) *Hemraj & Co Sdn Bhd v. Tenaga Nasional Bhd* [2023] 1 CLJ 651.

[154] As a matter of policy, it is not open for this court to reverse a decision of another panel of this court on the doctrine which was given so recently, save and except in situations where "it appears patently clear that the earlier decision was given in defiance of an express statutory provision that was overlooked by this court. Equally where a serious error is embodied in a decision of this court that has distorted the law, in which case the sooner it is corrected the better." (*Koperasi Rakyat Bhd v. Harta Empat Sdn Bhd* [2000] 3 CLJ 719 at pp. 196 to 197). It has not been shown by the plaintiff that the decision in *Dr Kok* was based on a serious error of law.

[155] Thirdly, the decision of the English Court of Appeal in *Hughes v. Rattan* [2022] EWCA Civ 107 applied the *ratio decidendi* and the identifying features which were expounded in *Woodland*. This is evident from the statement of Lord Justice Bean at para. 50:

> 50. *Woodland* is now the leading case on non-delegable duties of care. At para 73 Lord Sumption identified five cumulative factors (the *Woodland* factors) which indicate the existence of such a duty.

[156] Counsel for the plaintiff submits that in *Hughes v. Rattan,* the defendant was found liable premised upon the non-delegable duty of care and hence, appears to be a departure from what *Woodland* has prescribed.

[157] However, that is far from it, as *Hughes v. Rattan* was decided based on its own sets of facts and guided by the identifying features as formulated in *Woodland*, as can be discerned from the judgment of Lord Justice Bean which held that:

> 71. I also consider that the judge was right to find that the Claimant satisfied all the factors identified by Lord Sumption at paragraph 23 of *Woodland* as giving rise to a non-delegable duty of care:
>
> (1) In the first factor "patient" must include anyone receiving treatment from a dentist.
>
> (2) Turning to the second factor, *an antecedent relationship between the Claimant and the Defendant was established at the latest on each occasion when the Claimant signed the Personal Dental Treatment Plan,* which she was required to do before any NHS treatment was carried out. That relationship placed the Claimant in the actual care of the Defendant, not because he was a dentist himself but because he was the owner of the Practice ... The duty owed by Dr. Rattan was a positive or affirmative one to protect the patient from injury; and it involved an element of control over the patient.
>
> (3) As for the third factor, the Claimant had no control over how the Defendant chose to perform his obligations, whether personally or through employees or third parties. (emphasis added)

[158] In *Hughes v. Rattan,* the material facts are:

(i) the dental clinic was a sole proprietorship comprising solely of the defendant dentist.

(ii) the patient/claimant was admitted as a patient of the clinic pursuant to a written contract (personal dental treatment plan) between the claimant and the dental clinic in advance of each treatment session, which in fact and in law was between the claimant and the defendant dentist himself.

(iii) the personal dental treatment plan was signed by the claimant which named the defendant dentist as the provider of dental treatment and which stated the "dentist named on this form is providing you with the course of the treatment." There is no other dentist mentioned in the form.

(iv) the claimant was not treated by the defendant dentist himself.

(v) this written contract allowed the defendant dentist to subcontract his obligations under the contract.

(vi) the claim by the claimant was against three associate dentists and one trainee dentist.

(vii) the associates were self-employed dentists who were subcontracted to work for the defendant dentist. They were thus independent contractors who were delegated the obligations/duties of the dentist.

(viii) the defendant provided the UK National Health Service (NHS) dental care pursuant to the general dental services contract with the local primary care trust.

(ix) the claimant's dental treatment was paid for by the NHS.

(x) the claimant alleged that the defendant dentist owed her a non-delegable duty of care and argued that he should be personally liable for any negligence in the dental work subcontracted by the defendant dentist to "the associates" and the trainee dentist.

[159] What is pertinent in *Hughes v. Rattan* is that the contract (written contract for the personal dental treatment plan) between the claimant and the defendant clinic for treatment was to be provided by the sole proprietor which is the defendant dentist himself. This indicates that there was an antecedent relationship between the defendant and the plaintiff whereby the defendant had assumed responsibility for the claimant (which is a pertinent identifying feature as enunciated in *Woodland*), which is absent in our present appeal, which I will elaborate in the later part of this judgment.

[160] Given the aforesaid, it cannot be said that *Hughes v. Rattan* has gone beyond the principles as stated in *Woodland* and *Dr Kok Choong Seng* in applying the doctrine of non-delegable duty of care in a given case.

[161] The factual matrix surrounding the plaintiff's admission to D3 can be seen from the findings by the learned trial judge, which is as follows:

> [57] D3 highlighted the fact that the plaintiff's predicament arose from the surgery that he underwent in another hospital, Subang Jaya Medical Center (SJMC) following which after discharge from SJMC he suffered bleeding from the operation site in the early hours of the morning in question. Despite advice from the surgeon concerned to having the plaintiff brought immediately to SJMC, his wife (PW3) decided to seek treatment at D3 due to time factor and shorter distance from their home.

A [58] D3 also drew the court's attention to the fact that the plaintiff had not proffered any explanation or evidence for the cause of the post-operative bleeding.

[162] The patient was earlier treated by another surgeon in SJMC. His admission to D3 was an emergency situation. There is no antecedent
B relationship between D3 with the patient. Therefore, D3 has not assumed a positive duty to protect the patient from harm/injury. At the material time, when the patient was admitted, D3 provided the relevant facilities, equipment, administrative facilities required for his admission and management of his ailment and treatment at the Accident and Emergency
C Department. The only negligent act was that of D2 in intubating the patient. There was no finding of fact by the learned trial judge that D3 was negligent in its selection of D1 and D2, provision of facilities, or system of work, as can be discerned from the following paragraphs of the judgment:

D [63] Notably the crux of the plaintiff's claim revolved around the failure of D2 together with D1 to secure the airway urgently and to discuss the options to achieve this result as stressed by DW3's expert ... A crucial point correctly made by D3 was that the "... option to secure the airway is purely a clinical matter, which is within the purview or expertise of the medical doctor/specialist. It would appear from the evidence on record that neither specialist/clinician ... had discussed with the plaintiff, the
E options to secure the airway. This is purely a matter of professional or clinical judgment, and the responsibility to advise the plaintiff on the options to secure the airway, lay with DW3 (D2) together with DW1 (D1)." As alluded to earlier, it was a judgment call within the expertise mainly DW3 when such judgments are to be exercised. The Hospital as the employer could not be faulted or held liable for any negligence
F vicariously where no breach of duty of care by the Hospital was proved.

[64] The same applied to the administration of anaesthesia to the plaintiff which was purely a clinical decision in the interest of the patient. DW3 took the necessary steps that she deemed fit to facilitate intubation of the airway, including rendering the patient unconscious and paralysed but
G could only intubate him on her second attempt.

[65] In this regard the plaintiff's expert (PW2) only levelled criticism at DW3 for the manner she induced anaesthesia to the patient without first clearing the airway leading to serious consequences that according to DW3, could have been avoided, no criticism was directed at the service
H and treatment provided by D3 to the plaintiff or the facilities available at D3 for being inadequate.

[163] As to the second feature requirement (antecedent relationship) as required in *Woodland*, is not satisfied on the facts of the present appeal, the questions of how the hospital chooses to perform the duty (the third feature),
I the hospital's delegation of an integral part of that duty (the fourth feature), and the D2's negligence in the performance of the duty (the fifth feature) do not arise. Therefore, the non-delegable nature of the duty on D3 was not engaged.

[164] In addition to the findings that non-delegable duty of care against D3 is not applicable, the High Court made findings of fact that D2 is an independent contractor with D3.

[165] Independent contractors exist based on facts, namely function, role and relationships between individuals. It is not a legal fiction as contended by counsel for the plaintiff. In this regard, s. 4.6 of the residential consultant agreement signed by D2 with D3 is relevant which clearly states that D2 is an independent contractor with D3, and not the agent, servant or representative of D3. It further provides that D2 shall be personally liable for any acts of negligence or omission committed by her or by her agents in the conduct of her professional practice at the hospital. D3 shall not be responsible for any tortious acts of D2 and D2 undertakes to fully indemnify D3 in respect of any claims or actions brought against D3 by any persons from any tortious or negligent acts of omissions of D2 or her agents. The present appeal falls neatly within the established category of independent contractors. It is a straightforward case of a true independent contractor, where there is no necessity to go through the circuitous route to invoke the principle of a non-delegable duty so as to make D3 liable, when the direct course of remedy according to torts law is readily available to the victim. In this regard, this court in *Dr Kok Choong Seng* has addressed and highlighted this precise issue:

> [89] It must be borne in mind that the expanded test of "relationships akin to employment" in *Various Claimants* was developed in the context of that particular case, where the extraordinary nature of the relationship between the teaching brothers and the Institute, *though involving a high degree of control and all elements of an employment relationship, do not fall neatly within established categories of employees or independent contractors.*
>
> (emphasis added)

[166] Lord Sumption has also underlined the limits of the expanded test of "relationships akin to employment" in *Woodland* when he stated:

> [3] The boundaries of vicarious liability have been expanded by recent decisions of the courts to embrace tortfeasors who are not employees of the defendant, but stand in a relationship which is sufficiently analogous to employment: *Various Claimants v. Catholic Child Welfare Society and others* [2013] 1 All ER 670 ... **But it has never extended to the negligence of those who are truly independent contractors.** (emphasis added)

[167] In our present appeal, the fact that D2 charges consultancy fees and operation fees for her patients and D3 did not pay salary to D2, no EPF contributions support the inference that the operation was part of D2's independent business and that D2 is an independent contractor of D3.

[168] The present case is unlike *Woodland* or *Armes v. Nottinghamshire County Council* [2017] UKSC 60 where the doctrine provides the essential context justifying for the policy decision as evident from the supplementary judgment of Baroness Hale. She explicitly rationalised the context of the

primary policy justification for the decision in *Woodland*, and emphasised that, if a non-delegable duty did not arise on the facts, there would be an unsatisfactory and inconsistent effect and anomaly in the law, namely, that private schools (contractually) and schools using their own employees (vicarious liability) would both be liable for a negligently conducted swimming lesson, whilst a school employing an independent contractor would not. In that sense, the decision would not make sense to ordinary people (para. 30 of *Woodland*). The decision was thus influenced by policy considerations that the innocent victim (be it from Government or private schools) would equally be able to obtain compensation for the negligent act, be it employees of schools or independent contractors.

[169] Similarly in *Armes v. Nottinghamshire County Council,* the majority of the Supreme Court, in allowing the appeal and the claim, decided that the local authority was vicariously liable for the abuse committed by foster parents, considered the policy justifications as set out by Lord Phillips in *Various Claimants v. Institute Of Brothers Of The Christian Schools* [2013] 1 All ER 670 to ensure compensation for the harm suffered by innocent claimants as an important factor. The local authority could more easily compensate the victim and can be expected to have insured against the liability, than foster parents who might have insufficient means (para. 63 of *Armes v. Nottinghamshire County Council*). As in *Woodland*, the Supreme Court in *Armes v. Nottinghamshire County Council* also addressed the anomaly in the law where the man on the ground would be perplexed if the law is such that the local authority could be held vicariously liable for the abuse of the child by a member of the staff but not liable for the abuse of a child in the care of foster parents. It is also to be noted that the policy for the Supreme Court for the extension of vicarious liability was to ensure compensation and remedy for the innocent victims in the field of non-delegable duty of care, regardless of whether the victim is under the care of the local authority or the foster parents.

[170] Further, the five defining features of *Woodland,* which Lord Sumption advocated, is premised on schools which involved school children who were placed in the custody, charge or care of the school, where a particular high degree of care is called for. Lord Sumption also included in the case of prisons where prisoners are taken into custody. In both situations, the feature of an antecedent relationship exists between the school and student or prison authorities and detainees where there is custody, control and charge of the school children and detainees respectively. The antecedent relationship was formed when the students were taken into custody with the school whereas for the detainees, when they were placed under the charge and custody of the prison authorities. It was also the integral duty of the school (to provide education to the school children) and the prison authorities (to provide medical treatment to the prisoners) respectively, who were under their care

and custody. Out of these antecedent relationships, third parties' services are deployed by the school (provide swimming lessons to school children) or by the prison authorities (to provide medical treatment to the detainees) whereby these third parties were negligent in providing the same. Such administration of providing swimming lessons to the school children or administration of medical treatment to the detainees arose directly out of the enrolment of the children into the school or out of the prison authority's detention of the detainees. These arose as part of the integral part of the positive duty the school or the prison authority assumed, towards the school children or the prison detainees respectively, notwithstanding that the performance of the duty had been delegated to a private contractor. In *Woodland*, Baroness Hale provides the basis in making the school liable:

> [34] ... The reason why the ... school is liable is that ... the school has undertaken to teach the pupil, and that responsibility is not discharged simply by choosing apparently competent people to do it. The ... school remains personally responsible to see that care is taken in doing it.

(Also refer to Coulson J in *GB v. Home Office* [2015] EWHC 819 with regards to detention of detainees in prison centres).

[171] In such circumstances, it is possible to impute that the school or prison has taken custody of the students or prisoners, had assumed a positive duty to protect them from harm. The independent contractors engaged by the schools or the prisons to provide service for the students or the prisoners, would be for or on behalf of the schools or the prisons, respectively. It is in such circumstances that the school or the prison has delegated its integral function that is required of them for those under their charge and custody.

[172] In contrast to our present appeal, it cannot be imputed that there is an assumption of a duty on the part of D3 to protect the patient from harm because there is no antecedent relationship between the patient and D3. This is a case where the patient went to D3 for an urgent medical care and treatment which was provided by D1 and D2, who were, undisputedly, independent contractors. In this respect, although D3 is not a public body, it is indeed providing critical health services (para. 25 of *Woodland*).

[173] Apart from the absence of an antecedent relationship between the patient and D3 in the present appeal to impose a non-delegable duty of care on D3, there is no compelling public policy justification for such an imposition. The normal application of the principle of liability of independent contractors in torts law would not leave the patient without remedy/compensation, as evidenced from the award of damages granted by the Court of Appeal.

[174] In support of applying the doctrine against D3, counsel for the plaintiff submits on the holding out by D3 in the website which states:

A As a patient of Columbia Asia Hospital, patients benefit from advanced medical diagnostics, treatment and personal care that only comes in facilities where the focus is on each patient. Our facilities are comprehensive so you can rest assured that we have all that you need for your treatments and procedures. State-of-the art equipment ensures that we are up to date with medical technology and updates. To find out what
B we have to offer, please see the list below:

As a patient of Columbia Asia Hospital, you can expect:

To be informed of your medical treatment and care.

To be treated with courtesy and respect.

C To be provided with adequate information and informed consent.

To be provided with a channel to address your feedback.

To be informed of the estimated charges.

To see an itemized bill upon request.

D To know the identity and professional status of your care provider.

To be ensured the privacy and confidentiality of your medical record.

To receive care in an environment conducive to good health.

E **[175]** Counsel for the plaintiff also submits that D3 also used its note paper from the medical records and the contractual documents (including the bills). It included in the bill, its charges and also the charges for the services rendered on behalf of D3 (because it was a provider of healthcare) by its independent contractor doctors and its employees. Counsel for the plaintiff
F further submits that the whole bill sums were to be paid to the D3 (because of a contractual relationship with the patient and no part of the sums were to be paid directly to any independent contractor).

[176] With regard to the aforesaid, I am of the view that, the issue of holding
G out, points to the fact as to what "facilities" D3 has to offer to patients who are admitted to D3. This, by itself, is not determinative that D3 owes a non-delegable duty of care to the patient. In any event, it is not this "holding out" that attracted or lured the patient or the plaintiff into coming to D3. It is more of an emergency dire situation as the patient was bleeding profusely and D3 happened to be nearer to home.

H **[177]** The fact of the note paper being that of D3, the way the charges are billed and not being paid directly to the independent contractors are all inconsequential in the determination of whether D3 owes a non-delegable duty of care. It is also incorrect to say that the whole bill sums go to D3, because of a contractual relationship with the patient and no part of the sums
I were to be paid directly to any independent contractor. Counsel for the plaintiff suggests that a hospital takes a share of a doctor's charges for

treatment provided to patients. That is also incorrect because as independent contractors, D1 and D2's charges on the services provided by them, that are collected by the hospital, go to them and not the hospital. The hospital provides administrative services, charges for using the venue and equipment to the independent contractors whereby they collect payment from patients for itself in respect of hospital charges and for the independent contractors in respect of the doctors' charges. The hospital charges for the administrative services and charges provided to the independent contractors. Hence, it cannot be said that the independent contractor's private practice with the service of the hospital is conflated thereby imposing liability for the doctors' negligence on to the hospital premised upon non-delegable duty of care. The fee charges collected by the D2 (who is an independent contractor) point to the fact that the independent contractor and the hospital are separate business entities. In any event, non-delegable duty does not turn on these factors.

[178] On the "control" issue of independent contractors *vis-à-vis* the medical practitioners by D3 by virtue of the provision in the resident consultant agreement where they are required to be on call duty during emergency and D3 has the right to terminate them in cases where they failed to follow certain procedures or directions; those are terms and condition of an agreement entered into between D3 and D2 who are expressly stated as independent contractors to be able to use the medical facilities and equipment provided by D3. From the resident consultant agreement, D2's services are not subject to D3's control. D3 has no control on how D2 perform her principal duty, namely, to diagnose, make clinical judgment on treatment of the patient during the emergency. The right to terminate the services of D2 is a term in the agreement in the event of any breach of the agreement entered between D2 and D3 which is the normal consequence in any contract.

[179] Hence, issues on "holding out", "profit or fees sharing", "usage of the same note paper as D3 by the independent contractor", and "control" are not the determinative factors that would determine the existence of the non-delegable duty of care in our present case. In the absence of antecedent relationship between the patient and D3, there is no positive duty imposed on D3 in respect of the conduct of the management of the patient and the operation. Given the aforesaid, the courts below did not err in making its findings on the facts, that non-delegable duty of care against D3 is not applicable.

[180] Above all, question (i) is not novel. *Woodland* and *Dr Kok Choong Seng*'s case settled the law on the applicability of the principle of non-delegable duty of care. The application of the doctrine is facts-sensitive (refer to para. 70 of the judgment of *Dr Kok Choong Seng*) and the case of *Rattan v. Hughes* applied the *ratio* in *Woodland*. Never did *Rattan v. Hughes* depart from *Woodland* or *Dr Kok Choong Seng*. I therefore decline to answer question (i).

Question (ii)

[181] There is no prohibition in law for the common law tort of negligence to co-exist with the breach of separate duties of care imposed either under contract and/or by statute (if such is created by statute).

[182] The question and the answer to question (ii) are of no relevance to D3's liability as no contract or any specific statutory provisions have been pleaded or invoked against D3. Neither was any evidence led by the plaintiff at trial to that effect.

[183] There was no finding made by the courts below of any wrong committed by D3, be it common law negligence, breach of any contract or statutory duty.

[184] The question is not premised on the findings of the courts below. In any event, the answer would not have any determinative effect on the present appeal. I decline to answer question (ii).

Question (iii)

[185] This issue is settled, if not trite. Hence, the question posed is not novel. Imposition of liability is not dependent on impecuniosity as held in *Dr Kok* at p. 711:

> [69] ... Non-delegable duties are not imposed based on financial means or profit; ... To allow liability to be imposed not based on principle but on whoever has the deepest pockets would, to borrow the words of Glanville Williams, "render unintelligible the distinction between tort liability and national insurance".

[186] Insufficiency of indemnity for malpractice is never the consideration in the determination of non-delegable duty of care of private hospitals. The present appeal appears to impose liability on D3 because of the insufficiency of the medical indemnity insurance of D2 to meet up with the amount of the award of damages awarded. There is nothing to stop the plaintiff from making a claim against D2. Neither is it the pre-requisite to a claim herein that D2 should be adequately insured. Liability does not depend on being adequately insured. Nor has it been shown that D2 is insolvent or a person without means.

[187] Relevant to this issue is the comment by Lord Reed in *Cox v. Ministry Of Justice* [2016] UKSC 10. Although he was addressing the underlying policy of vicarious liability which was said "to ensure that liability for tortious wrongs is borne by the defendant who has the means to compensate the victims", the comments are relevant to the issue at hand:

> [20] The five factors which Lord Phillips mentioned in para 35 are not all equally significant. The first - that the defendant is more likely than the tortfeasor to have the means to compensate the victim, and can be expected to have insured against vicarious liability – did not feature in the remainder of the judgment, and is unlikely to be of independent significance in most cases. It is, of course, true that where an individual is employed under a contract of employment, his employer is likely to have deeper pocket and can in any event be expected to have insured against vicarious liability. Neither of these, however is a principled justification for imposing vicarious liability. *The mere possession of wealth is not in itself any ground for imposing liability. As for insurance, employers insure themselves because they are liable; they are not liable because they have insured themselves.* (emphasis added)

[188] Again, this question is not novel as the issue raised in the question is settled by the case laws as aforesaid. I decline to answer question (iii).

Question (iv)

[189] Question (iv) is dependent on the answer to question (iii) to be in the affirmative.

[190] As I have declined to answer question (iii), I also decline to answer question (iv).

[191] In any event, for completeness, it is the principle of non-delegable duty of care that it is an exception to the no-fault principle. If the principle applies (which ought not to be, in the present appeal), there is no question of D3 escaping liability merely on the reason that D2 is an independent contractor.

Question (v)

[192] Question (v) raises the issue of whether the owner and manager of a private hospital are under a statutory duty of care, independent of a duty in negligence or contract, under the PHFSA and Regulations.

[193] Firstly, the PHFSA uses the term "licensee" rather than "manager" or "owner". I have addressed this issue in question (i).

[194] Secondly, the particular question is framed in a broad manner with no specific reference to any statutory provision. The pleadings are also devoid of any reference to any provisions of the law or regulations.

[195] Thirdly, the question did not state to whom is the statutory duty of care owed.

[196] At best, the allegations of negligence by the plaintiff against D3 is at para. 26.38 of the statement of claim where the plaintiff states as follows:

> Particulars of negligence and breach of contractual and other duties of the 3rd defendant and its servants and agents
>
> ...
>
> 26.38 failed to act in accordance with its statutory duties as provided under the Private Healthcare Facilities and Services Act 1998 and the subsidiary legislation thereunder regarding the provision of proper facilities and services, patient welfare and safety, staffing requirements, the recording, sharing and transmission of information, screening, investigations, diagnosis, treatment and advice, the giving of advice and information to patients and the taking of consent, the referral and transfer of patients, and advice and counselling regarding the likely cost and expense of the screening, investigations, diagnosis, treatment and management provided or to be provided

[197] In presenting its arguments in this respect before the Court of Appeal, the plaintiff only referred to reg. 11(4) stating that the defendant "should be found vicariously liable and also in breach of its non-contractual delegable duty of care". For clarity, reg. 11(4) provides:

> All registered medical practitioners or registered dental practitioners privileged to practise in the private healthcare facilities or services shall be considered as part of the organization.

[198] Counsel for the plaintiff submits that the services provided by medical practitioners who are independent contractors at D3 are integrated into the private healthcare facilities or services provided by D3. Counsel for the plaintiff referred to Lord Reed's suggestion in *Armes v. Nottinghamshire County Council* that "The most influential idea in modern times has been that it is just that an enterprise which takes the benefit of activities carried out by a person integrated into its organisation should also bear the cost of harm wrongfully caused by that person in the course of those activities" (at para. 67). Again, this should not be taken out of context. A reading of the entire para. 67 of the case would provide a better understanding of why the statement was made. It cannot be read by nit-picking certain sentences in the said paragraph. In any event, that statement does not represent the law, *ratio* nor justification in imposing non-delegable duty of care. Neither does it provide clarity as to what does "enterprise", "integrated", and "benefits" mean.

[199] In any event, reg. 11(4) is not the determinative provision that imposes a non-delegable duty of care on D3. At best, it shows that the medical practitioners form part of the organisation of D3. Nothing stated about liability of D3 in the provision and nothing turns on it. This is not the correct approach in trying to pin non-delegable duty of care on D3 for the negligent act of the medical practitioner who is expressly described as "independent contractor" by virtue of her resident consultant agreement with D3. I do agree that labels ascribed to a wrongdoer are not the determining

factor to determine the existence of non-delegable duty of care. However, one is bound to refer to the principles and the five identifying features as held in *Woodland* and *Dr Kok Choong Seng* in making determination of whether such non-delegable duty of care exists, which on the facts of the present appeal, has not been fulfilled. Again, I need to emphasise again, the policy context in which *Woodland* was decided and Lord Sumption's cautionary words that imposing the non-delegable duty of care should be an exception rather than the rule.

[200] With regards to whether the owner and manager of a private hospital are under a statutory duty of care, independent of a duty in negligence or contract, under the PHFSA and Regulations, it is important to refer to the provisions of the statute and regulations.

[201] The PHFSA permits sole proprietors, partnerships, body corporates and societies to apply for licences "to operate or provide a private healthcare facility or service other than a private medical clinic or a private dental clinic".

[202] Referring to the provisions in the PHFSA and Regulations, specific to emergency situation as in the present appeal, s. 78 of the PHFSA and reg. 14 thereof states that the management and treatment of a patient "vested" with the medical practitioner and that the patient is under the "direct care or treatment" of the medical practitioner. The words "vests" and "direct care or treatment" in s. 78 and reg. 14 bear great significance in delineating the duty of a licensee (as for D3) and medical practitioners (as for D2).

[203] The duty of D3 as is provided under the PHFSA and the Regulations is to ensure that the management, medical care and treatment that the patient needed on an urgent basis were made available and provided by the registered medical practitioners at the material time. In this regard, s. 38 of the PHFSA provides that:

> 38 (1) Every licensed and registered private healthcare facility or service shall at all times be **capable of instituting and making available,** essential life saving measures and implementing emergency procedures on any person requiring such treatment or services.
>
> (2) The nature and scope of such emergency measures, procedures and services shall be as prescribed. (emphasis added)

[204] Regulation 230 states:

> 230. (1) All private healthcare facilities or services shall have a well-defined care system for providing basic outpatient emergency care services to any occasional emergency patient who comes or is brought to the private healthcare facilities or services by chance.
>
> (2) The nature and scope of such emergency care services shall be in accordance with the private healthcare facility or service's capabilities.

(3) All private healthcare facilities or services shall provide immediate emergency care services which include life-saving procedures when life, organ or limb is in jeopardy and management of emergency psychiatric conditions.

(4) Assessment of a patient's condition to determine the nature, urgency and severity of the patient's immediate medical need and the timing and place of the patient care and treatment in a private healthcare facility or service shall be done by a registered nurse, registered medical assistant or a registered medical practitioner and in the case of a dental service, by a registered dental practitioner.
(2) Notwithstanding paragraph (1)(a), different persons may be appointed to manage and assume the duties and responsibilities relating to non-clinical matters including financial, administration and management of non-clinical resources.

[205] Section 31 of the PHFSA provides:

(1) A licensee or a holder of a certificate of registration in respect of a licensed or registered healthcare facility or service shall:

(a) ensure that the licensed or registered private healthcare facility or service is maintained or operated by a person in charge;

(b) inspect the licensed or registered private healthcare facility or service in such manner and at such frequency as may be prescribed;

(c) ensure that persons employed or engaged by the licensed or registered private healthcare facility or service are registered under any law regulating their registration, or in the absence of any such law, hold such qualification and experience as are recognized by the Director General; and

(d) comply with such other duties and responsibilities as may be prescribed.

(2) Notwithstanding paragraph (1)(a), *different persons may be appointed to manage and assume the duties and responsibilities relating to non-clinical matters including financial, administration and management of non-clinical resources.*

(3) Where a licensee or a holder of a certificate of registration who is a sole proprietor contravenes subsection (1), he commits an offence and shall be liable on conviction to a fine not exceeding one hundred thousand ringgit or to imprisonment for a term not exceeding two years or to both.

(4) Where a licensee or a holder of a certificate of registration who is a body corporate, partnership or society contravenes subsection (1), it commits an offence and shall be liable, on conviction to a fine not exceeding three hundred thousand ringgit.

(5) Where an offence under subsection (1) is committed by a body corporate, a partnership or a society:

(a) in the case of a body corporate, the person responsible for the body corporate; A

(b) in the case of a partnership, every partner in the partnership;

(c) in the case of a society, its office bearers.

shall also be guilty of the offence and shall be liable, on conviction to a fine not exceeding one hundred thousand ringgit or to imprisonment for a term not exceeding two years or to both. (emphasis added) B

[206] There is no evidence adduced to show that s. 38 of the Act or the Regulations thereunder, were not complied with. Neither was there any allegation by the plaintiff that there was negligence in the selection by D3 of D2. The function of D3 in "instituting and making available, essential life saving measures and implementing emergency procedures on any person requiring such treatment or services" is akin to an act to arrange for the facilities to be made available for the treatment of the patient. In this case, D3 has ensured that D2 are registered and skilled in the management and treatment of patient. Therefore, in the absence of the negligence on the part of D3 in the selection of D2, D3 would not be liable for the negligence of D2, who is an independent contractor, whereupon analysis, the duty of D3 is not to perform the management and treatment of the patients but to make available the essential life-saving measures and implementing emergency procedures on the patient requiring such treatment or services as required under the PHFSA and the Regulations. C D E

[207] It is trite law that it is the person who commits the tortious act or breaches a contractual duty that is liable for any negligence. That being the case, liability for breach of duty in tort (if any) would be imposed on the licensee which/who, operates a private hospital, assuming that it is that licensee who contracts with a patient, for breach of a contractual duty. F

[208] Assuming that the owner or manager of the private hospital is synonymous with the licensee, then the owner or manager is liable for any such breach of duty. This is supported by s. 31 of the PHFSA, which imposes criminal liability on the licensee and the persons controlling the registered healthcare facility. However, in the present appeal, there is no such evidence of any breach of contractual duty. G

[209] The Privy Council in *Gulf View Medical Centre Ltd v. Tesheira (The Executrix Of The Estate of Russel Tesheira) (Trinidad And Tobago)* [2022] UKPC 38, in a unanimous decision, cited with approval in *Woodland* and *Armes v. Nottinghamshire County Council*, which is an appeal arising from decisions on claims for medical negligence against a private hospital, a consultant urological surgeon and a consultant anaesthetist and held that: H

[51] A non-delegable duty of care arise under statute (see *Armes v. Nottinghamshire County Council* [2018] AC 355 at para 38) or at common law (see *Woodland v. Swimming Teachers Association and others* [2014] AC 537) or alternatively by admission on the pleadings ... I

[210] The PHFSA nor its Regulations do not impose liability on an owner or manager for civil claims where they are not the licensee. Where the licensee is a company, this preclusion applies to its shareholders, directors and management.

[211] There is no statutory provision imposing responsibility or liability for negligence, fault or wrong on D3 (the licensee) committed by D2, who is an independent contractor. To infer from the provisions of the Act and its Regulations on such liability would be an overstretch. Such liability, if any, arises under the common law of liability under vicarious liability or non-delegable duty of care. Neither did the plaintiff indicate in her pleadings nor submissions, as to which provision of the PHFSA or the Regulations did D3 breached, whereby non-delegable duty of care can be imposed. At best, the allegations of negligence by the plaintiff against D3 are as stated at para. 26.38 of the statement of claim, which the High Court had made findings of facts that it was not proven.

[212] Given the aforesaid, the answer to question (v) would be in the negative.

Question (vi)

[213] Answering this question would not have any effect on the appeal for the following reasons.

[214] Firstly, the High Court and the Court of Appeal had made concurrent findings that D3 is not liable for the negligent act. D2 was found to be liable for the same and an award of damages had been ordered against D2. There is no appeal by D2 and neither is there any appeal by the plaintiff against the findings of liability and damages against D2 by the courts below.

[215] Secondly, the appeal before this court is only against the dismissal of the claim under non-delegable duty of care against D3. To that extent, the findings of liability and the award of damages against D2 stands as final.

[216] Hence, even assuming for a moment, that liability is found against D3 now (which ought not to be), the quantum of damages (of which D2 has been found to be liable by the courts below) can no longer be varied, nor transferred to D3.

[217] The patient suffered injury from one negligent act. There cannot be two sets of awards for the same negligent act. I agree with the submission of counsel for D3 that "the assessment of damages is a determination of damages suffered by the patient and not how much damages each defendant is to separately bear for the same tort."

[218] Thirdly, D3 is not a joint tortfeasor with D2, as it was never pleaded as such. Hence, there is no issue of the apportionment of damages between D2 and D3. Moreover, the damages cannot be split because the premise of

liability on D2 and D3 are distinct and separate. If this court found that D3 owes a non-delegable duty of care, then D3 ought to be liable for the negligent act and liable to pay for the whole sum of damages. Then what is to become of the damages awarded to D2. It would create an absurd situation where D2 is liable as an independent contractor and liable for damages and that D3 is liable based on non-delegable duty of care and also liable to pay for damages as well.

[219] Given the aforesaid, both the courts below did not err in finding liability against D2 as an independent contractor and that D2 is liable to pay damages for the negligent act.

[220] Therefore, I decline to answer question (vi).

Question (vii)

[221] It is settled law by virtue of *Dr Kok Choong Seng* which held that the guiding principles as refined in *Woodland* be used as a starting point. As the imposition of a non-delegable duty of care is an onerous obligation, it is reiterated by this court in the same case that the proviso in *Woodland* that such duties should only be imposed where it is "fair, just and reasonable depending on the facts of each case" (see *Dr Kok Choong Seng* at p. 708).

[222] This was the overriding principle which was made subject to, in imposing the non-delegable duty of care, as can be discerned from the judgment by Lord Sumption:

> 25. The courts should be sensitive about imposing unreasonable financial burdens on those providing critical public services. A non-delegable duty of care should be imputed to schools only so far as it would be fair, just and reasonable to do so ...

[223] I am also reminded of the cautionary statement by Lady Hale which was reiterated by Lord Reed JSC in *Armes v. Nottinghamshire County Council*:

> 36. The five criteria set out by Lord Sumption were thus intended to identify circumstances in which the imposition of a non-delegable duty was fair, just and reasonable. It is important to bear in mind Lady Hale's cautionary observation that such judicial statements are not to be treated as if they were statutes, and can never be set in stone. Like other judicial statements, the criteria articulated by Lord Sumption JSC may need to be reconsidered and possibly refined, in particular contexts. **That does not, however mean that it is routinely necessary for the judge to determine what should be fair and just as a second stage of the analysis.**
>
> (emphasis added)

[224] What can be inferred from the aforesaid is that, although it should not be routinely necessary to determine whether the imposition of such a duty is fair, just and reasonable, such determination may be necessary to be considered in certain circumstances.

[225] This is reflected in the decisions of *Woodland* and *Armes v. Nottinghamshire County Council,* which were influenced by policy considerations and the court's view that claimants should be able to obtain compensation from defendants who are solvent as well as insured. The Supreme Court in *Armes v. Nottinghamshire County Council*, in allowing the appeal, held that the local authority was vicariously liable for the abuse committed by the foster parents considered the policy reasons as set out in *Various Claimants v. Institute Of Brothers Of The Christian Schools* [2013] 1 All ER 670 to ensure compensation for harm caused to innocent victims as an important factor. It is considered that most foster parents have insufficient means to be able to meet a substantial award of damages.

[226] In our present appeal, damages were awarded by the courts below to the patient against D2. D2 is insured and there is no evidence led that D2 have insufficient means to meet the award of damages. In other words, there is compensation awarded for the harm suffered. There is no issue the patient being left without any remedy. There is absolutely no basis for the plaintiff to impose liability based on the doctrine.

[227] In any event, since there is no non-delegable duty of care imposed on the D3, the issue of whether the imposition of such duty is just, fair and reasonable does not arise.

[228] Hence, the answer to question (vii) would be in the affirmative.

Other Issues

[229] Counsel for the plaintiff referred to the case of *Breakingbury v. Croad* [2021] Med LR 509, however, the negligence which was found was related to the core function of the dental practice which was sued. This can be found in the judgment:

> **Negligence related to a core function**
>
> 47. In my view this characteristic is readily met. **The pleaded allegations of negligence relate to the central function of the practice, namely the provision of dental services.**
>
> 48. Having found that the characteristics identified by Lord Sumption have been met. It is nevertheless necessary to stand back and ask whether it is right to impose a non-delegable duty. The characteristics are not a statute and as such the court must pause and consider the overall position. In so doing, it seems to me that there is good reason to impose a duty in this case. It is undoubtedly a cause of great concern to the defendant. It may well be something that the wider dental community might find unexpected. However, if one stands back and asks if a practice (here the defendant personally since he owns it) it should owe a duty to a patient for whose care they are paid by the Local health Board, then the answer must well be entitled to an indemnity from the individual

> associate dentists and that may well go some way to dealing with any perceived unfairness, but that is a matter for the practice and the associate. It should not, it seems to me, prevent a claimant recovering against the practice with whom she is registered and who have been paid for her care. (emphasis added)

[230] The words highlighted reflect the finding by the court that the delegation by the practice of its core function which means that there is an assumption of a positive duty to ensure that care is taken by whomsoever is delegated with the work which was an integral/core function of the practice. Hence, the findings that the characteristics identified by Lord Sumption has been met.

[231] However, caution must be exercised in referring to *Breakingbury v. Croad* as it is a County Court judgment. Reliance on County Court judgments sets a worrying trend as such judgment is not a binding precedent.

[232] On the *Vincent Manickam David (Suing By Himself & As Administrator Of The Estate Of Catherine Jeya Sellamah, Deceased) & Ors v. Dr S Hari Rajah & Anor* [2017] 8 CLJ 27; [2018] 2 MLJ 497's case referred to, by counsel for the plaintiff, *Dr Kok Choong Seng*, which has adopted and accepted the *ratio* of *Woodland* which has been applied in various cases post-*Dr Kok Choon Seng*. The facts disclosed that the patient was earlier admitted to the respondent hospital where she underwent surgery (indicating that there was an antecedent relationship between the patient and the hospital), unlike the facts in our present appeal. In any event, in *Vincent Manickam*, the hospital was found to be vicariously liable for the negligence of the surgeon.

Conclusion

[233] Time and again, it has been reiterated that the imposition of non-delegable duty of care is highly facts-sensitive. Accusations outside of well-established principles to say that such non-delegable duty of care exists needs to be properly scrutinised and applied with extreme caution, given that non-delegable duty is inconsistent with fault-based principles and is exceptional. The underlying legal framework in which the identifying features were crafted by Lord Sumption has substantial restrictions and controls and it would only be in exceptional situation before a court finds that the duty was a non-delegable one. The criteria for an antecedent relationship, positive duty and integral function have a high threshold to meet. The Supreme Court in *Woodland* has not widened the scope of non-delegable duty of care. Often, there is a tendency to look for a defendant who has deeper pockets, to satisfy compensation claims, under the guise of a non-delegable duty of care when there is a clear case of an independent contractor or employer-employee relationship, which sets a worrying trend.

[234] In the present appeal, D3 is providing critical health service, where the patient was treated earlier in another hospital and was brought to D3 due to a critical and emergency situation, a life-and-death situation. Lord Sumption had cautioned against imposing unreasonable financial burdens on those providing critical public services and that a non-delegable duty should be imputed only so far as it would be fair, just and reasonable to do so. Where the criteria of his framework are satisfied, the imposition of a non-delegable duty would not cast an unreasonable burden, however, that is not the case in the present appeal.

[235] Caution should be exercised when courts expand the area of liability of non-tortfeasors (where we are expanding areas of vicarious liability). Reason being, this is the realm of policy, which is an unfamiliar territory for the courts and if such duty ought to be expanded and imposed on private hospitals or medical institutions like D3, it would be wise for it to be provided by legislation since it affected medical institutions and the medical profession who are independent contractors, which technically are not being controlled in performance of their medical duty by hospitals like D3. Judicial legislation/pronouncement is always based on facts situation of a particular case which means the lines are blurred between vicarious liability and non-delegable duty of care, which adds up to the unpredictability in the application of the imposition of a non-delegable duty of care.

[236] As far as the present appeal is concerned, it is a clear and a straightforward case of negligence of an independent contractor, D2. There is no ambiguity in the relationship between D2 and D3 as evident from the resident consultant agreement. There is also no issue of the plaintiff being deprived of remedy or compensation for the negligence act of D2. Therefore, there is no necessity to invoke policy justification nor policy consideration to impose liability on D3 through the difficult route of the application of the doctrine of non-delegable duty of care for the negligence committed by its independent contractor, D2. This is unlike the facts as in:

(i) *Woodland* (where the vicarious liability is not applicable, and non-delegable duty provides appropriate means of securing equal protection to innocent victims);

(ii) *Armes v. Nottinghamshire County Council* (where without the application of the non-delegable duty of care, the decision would result in an unsatisfactory and inconsistent effect and anomaly in the law which would not make sense to people on the ground); or

(iii) *Cassidy v. Ministry Of Health* [1951] 2 KB 343 (where the courts were grappling with the issues of non-applicability of vicarious liability and the victim being left with no remedy/compensation or that the exact cause of the injury or the employee of the hospital that caused the injury could not be ascertained/identified).

The principle of non-delegable duty of care provides a tool in such cases, in the pursuit of social justice to circumvent the limitations of the doctrine of vicarious liability so as not to deprive the innocent victims of a remedy or compensation. In such cases, the imposition of a non-delegable duty of care is just, fair and reasonable. However, in our present appeal, it is the reverse. The imposition of the doctrine on D3 would not be fair, just and reasonable in the circumstances and would present a grossly unfair burden imposed on health institutions providing critical public health services, more so in emergency situations. I do agree with the submission of counsel for D3 that great care must be taken to avoid imposing unnecessary obstacles to the public in gaining access to healthcare.

[237] The doctrine of non-delegable duty is not applicable to the fact situation of the present appeal. Both the High Court and the Court of Appeal did not err in dismissing the claim against D3. There is no statutory duty imposed on D3 that would render D3 liable for the negligence of a registered medical practitioner who is an independent contractor and not an employee of the hospital.

[238] The answers to the questions posed are as follows:

Question (i) – decline to answer.

Question (ii) – decline to answer.

Question (iii) – decline to answer.

Question (iv) – decline to answer.

Question (v) – negative.

Question (vi) – decline to answer.

Question (vii) – affirmative.

The questions as answered above will not result in D3 being liable in respect of D2's negligence towards the patient.

[239] Given the aforesaid, the appeal is dismissed with costs to D3.